

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18-27 Film 389
5-24-67

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07270

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 3 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Mitchell Ave. | | | | d. STREET ADDRESS 400 Mitchell Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BETTY Middle VIRGINIA Last ANDERSON | | | | 4. DATE OF DEATH Month May Day 7 Year 1967 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 24, 1921 | | 9. AGE (In years last birthday) 45 yrs. | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 10b. KIND OF BUSINESS OR INDUSTRY goodwill inds. | | 11. BIRTHPLACE (State or foreign country) Rada, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Hugh R. Anderson | | | | 14. MOTHER'S MAIDEN NAME Olive Smith | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219-12-0705 | | 17. INFORMANT Address Hugh R. Anderson, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis, severe DUE TO (b) Pericarditis DUE TO (c) General arteriosclerosis & Arteriosclerotic heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5-5 yrs. 10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enterocolitis & benign nephrosclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md. | | | | | |
| EXAMINER'S NAME (Type) Edward W. Ditto, III | | 22. DATE SIGNED May 11 1967 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 5-10-67 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or town) (County) (State) Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR DATE MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M1
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07292

07271

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21.1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | | | d. STREET ADDRESS <u>1121 Fairview Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Thomas</u> Last <u>Arcidiacono</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 29, 1952</u> | | 9. AGE (In years last birthday) <u>14</u> yrs. | IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Arcidiacono</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Julia Fitzgerald</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-54-8037</u> | | 17. INFORMANT <u>Thomas Arcidiacono 1121 Fairview Rd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> DUE TO <u>9104</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by baseball</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>5/18/67</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ball Park</u> | | 20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Howard N. Weeks</u> | | EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED <u>5/29/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/29/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUN 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07293

07272

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Weverton c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Residence | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Weverton d. STREET ADDRESS RFD#2, Knoxville, Md. 21758 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First HAYWARD Middle LESLIE Last BAER | | 4. DATE OF DEATH Month May Day 28 Year 19 67 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 17, 1917 | | 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | 11. BIRTHPLACE (County & State, or foreign country) Brunswick, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Ollie Osborne Baer | | | | | | 14. MOTHER'S MAIDEN NAME Edna Mae Barnhart | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II | | | | 16. SOCIAL SECURITY NO. 579-03-5031 | | | | 17. INFORMANT Mrs. Elizabeth L. Baer RFD#2, Knoxville, Maryland 21758 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-CARCINOMA - of Lung 163X DUE TO (b) Local & generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 18 min. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) Midd 6 May 28 1967 | | | | | |
| 21. I certify that I (the hospital) attended the deceased from May 28, 1967 to May 28, 1967 that I (we) last saw the deceased alive on May 28, 1967 and that death occurred at 6:15 PM from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 6-1-67 | | 22b. DATE SIGNED 6-1-67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) C.E. Pruitt, M.D. | | | | | | 22d. ADDRESS Brunswick, Maryland 21716 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 5/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY Brownsville Heights | | | | 23d. LOCATION (City, town or county) (State) Brownsville, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE [Signature] | | | | | | ADDRESS Harpers Ferry, W.Va. | | 25a. RECEIVED BY REGISTRAR JUN 6 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedures followed, and the results obtained. It also discusses the errors and limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

4. The fourth part of the report is a summary of the work. It briefly reviews the main points of the report and states the conclusions. It also mentions the suggestions for further work.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07294

07273

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN Rt #2 | | | | c. LENGTH OF STAY IN 1b 21.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | e. STREET ADDRESS KING ST | | | |
| 3. NAME OF DECEASED (Type or print) First BOBBY Middle GIRL Last BRANZHOFF # 1 | | | | 4. DATE OF DEATH Month 5 Day 21 Year 1967 | | | |
| 5. SEX FEMALE W | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/20/67 | |
| 9. AGE (In years last birthday) 1 yrs. | | IF UNDER 1 YEAR Months 1 Days 1 | | IF UNDER 24 HRS. Hours 1 Min. 1 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) U-S-A | |
| 12. CITIZEN OF WHAT COUNTRY U-S-A | | | | | | | |
| 13. FATHER'S NAME CHARLES KELLER BRANZHOFF | | | | 14. MOTHER'S MAIDEN NAME NANCY DIAN BOYD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) NONE | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYALINE Membrane disease DUE TO (c) Immaturity | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/20/1967 to 5/21/1967 , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on 5/21/1967 , and that death occurred at 11:55 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Ronald Keyser | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/22/67 | |
| 22c. PHYSICIAN'S NAME (Type) RONALD E KEYSER | | | | 22d. ADDRESS 101 King Street HAGERSTOWN | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF MAY 23, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON COUNTY HOSPITAL | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND | |
| 24. FUNERAL DIRECTOR John Schaffer, Adm. Wash Co Hosp | | | | 25a. REC'D BY REGISTRAR MAY 26 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07295

CERTIFICATE OF DEATH

07274

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN #2 | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON County Hosp | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BABY GIRL BANZHOFF | | 4. DATE OF DEATH 5 21 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/20/67 |
| 9. AGE (In years last birthday) yrs. 5 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 4 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, Md. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME CHARLES KELLER BANZHOFF | | 14. MOTHER'S MAIDEN NAME NANCY DIAN BOYD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis DUE TO Immaturity of lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5/20 , 19 67 , to 5/21 , 19 67 , that (I) (we) last saw the deceased alive on 5/21 , 19 67 and that death occurred at 3:24 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ronald E. Keyser M.D. | | 22b. DATE SIGNED 5/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) RONALD E. KEYSER | | 22d. ADDRESS 101 KING ST HAGERSTOWN, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF MAY 23, 1967 | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON COUNTY HOSPITAL | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND |
| 24. FUNERAL DIRECTOR John Schoffer, Adm. Wash Co. Hosp | | 25a. REC'D BY REGISTRAR MAY 26 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

Ronald E. Keyser
 Ronald E. Keyser
 2/21 2/20 2/21 2/21 2/21
 2/21 2/21 2/21 2/21 2/21

Primarily

Primarily
 Primarily

no no

CHARLES KETER BANSHEE
 NANCY ANN BORD

Infant

Washington, D.C.

Female

Banshee

Washington County

Washington

2/21 2/21 2/21 2/21 2/21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

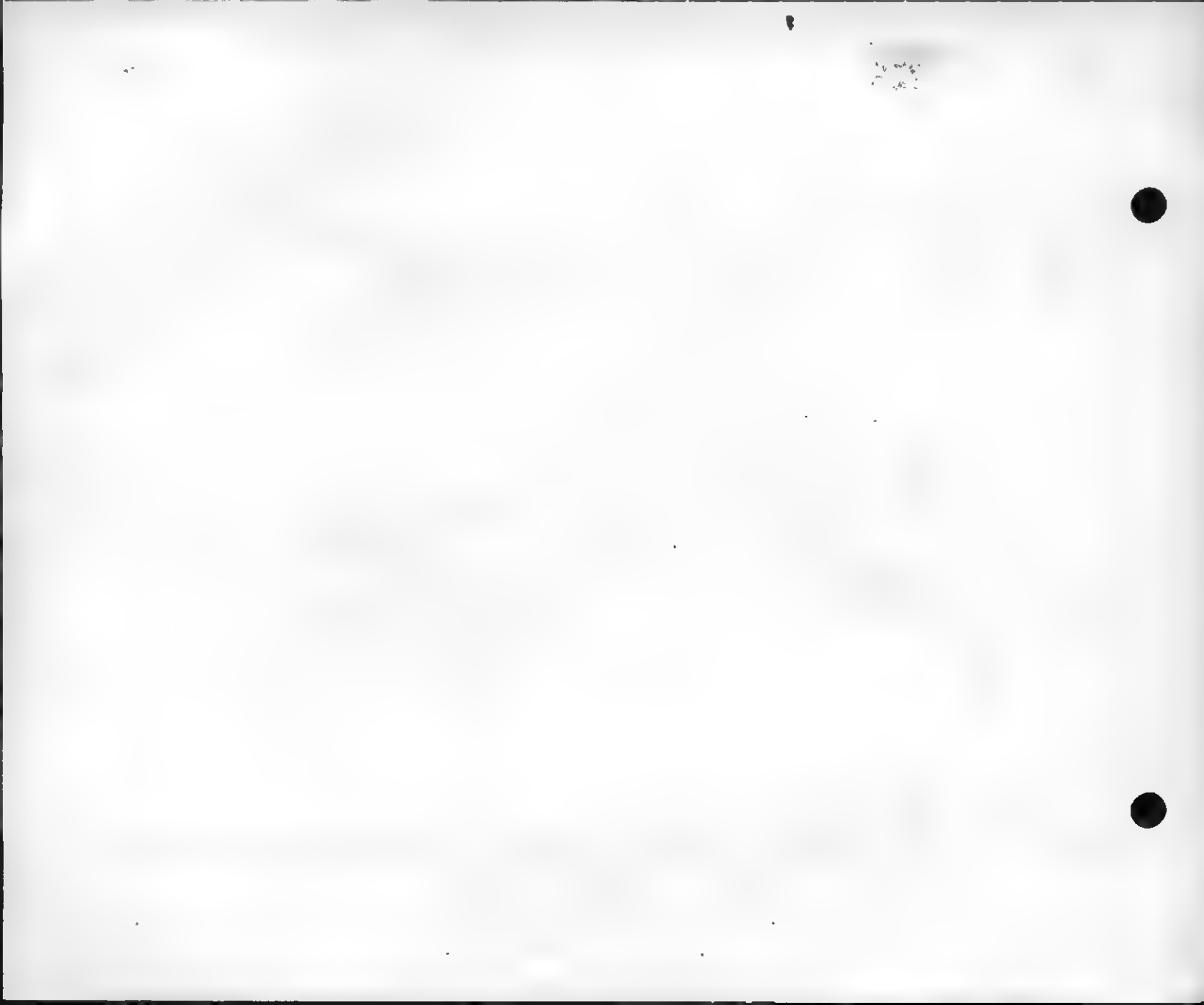
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07296

CERTIFICATE OF DEATH

07275

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 21214</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Homewood Church Home Inc</u> | | d. STREET ADDRESS <u>5609 Birchwood Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Matilda</u> Last <u>Benson</u> | | 4 DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Oct 24, 1876</u> |
| 9 AGE (in years last birthday) <u>90</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Milliner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Milliner</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas J. Benson</u> | | 14. MOTHER'S MAIDEN NAME <u>Matilda Whiting</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16 SOCIAL SECURITY NO. <u>219-05-6212A</u> | |
| 17 INFORMANT <u>Markell Wagner</u> | | Address <u>2750 Va Ave Williamsport, Md.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>413X</u> DUE TO <u>Styptostatic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Styptotensive cv. Disease</u> DUE TO (c) <u>17 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>65</u> , to <u>5-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> , 19 <u>67</u> , and that death occurred at <u>9:15 A.M.</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Robert P. Conrad</u> M.D. | | 22b. DATE SIGNED <u>5-20-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad, M.D.</u> | | 22d. ADDRESS <u>137 W. Washington Stagerstown, Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City or Town) (County) (State) |
| <u>Burial</u> | <u>May. 23. 1967</u> | <u>Baltimore Cemetery</u> | <u>Baltimore Md.</u> |
| 24 FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> | | 25a. RECD BY REGISTRAR <u>MAY 22 1967</u> | |
| ADDRESS <u>Baltimore Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

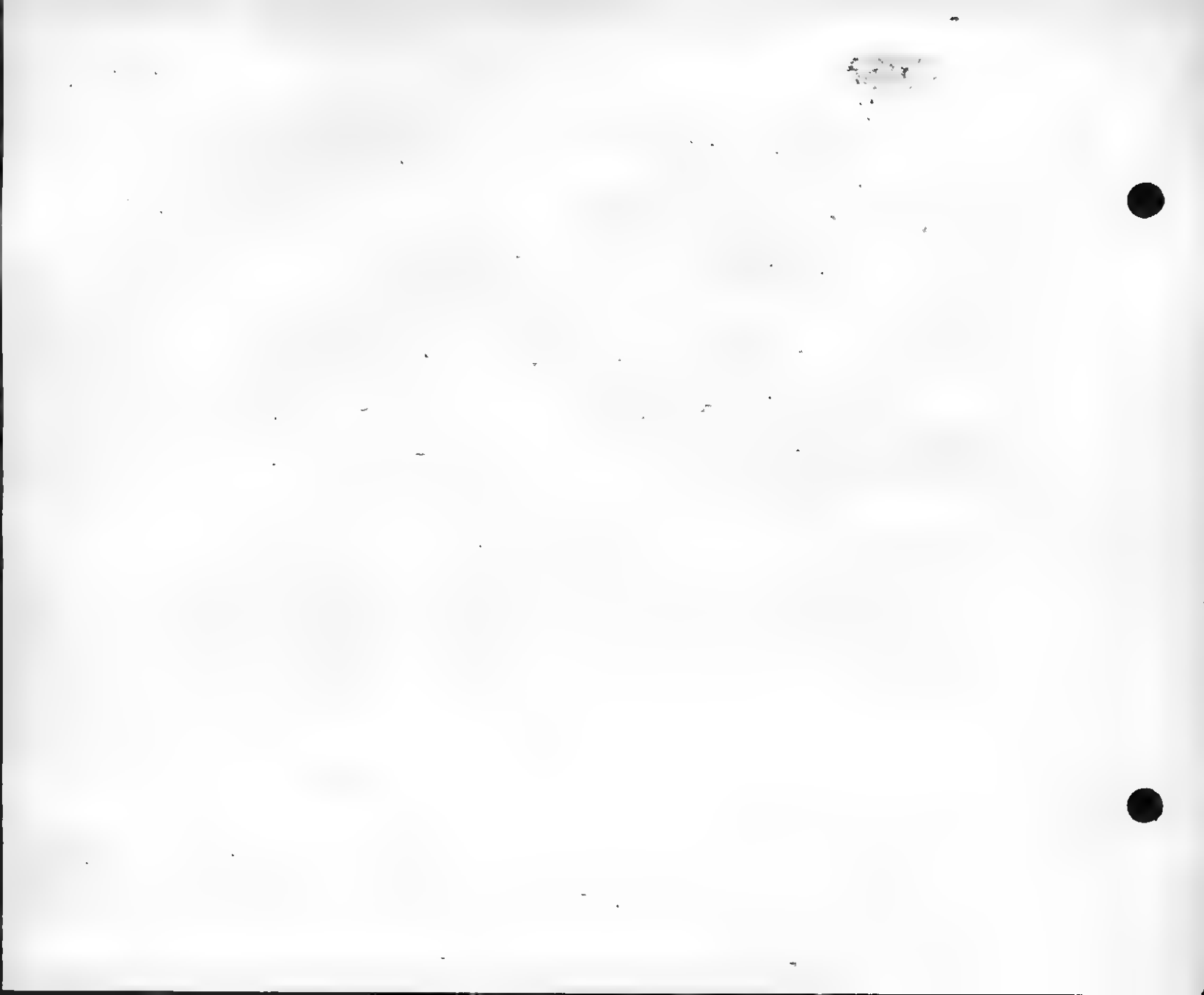
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07297

CERTIFICATE OF DEATH

07276

| | | | | | |
|---|--|---|--|--|---|
| 1. PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Pa.</u> b COUNTY <u>Franklin</u> | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Hagerstown</u> | | | c LENGTH OF STAY IN 1b — | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor</u> | | | d STREET ADDRESS <u>237 E. Balto. St.</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>ANNIE F. Binkley</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1967</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/20/1880</u> | | 9. AGE (in years last birthday) <u>87</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Antrim Twp., Pa.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Geo. W. Leshner</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Shank</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. — | | | 17. INFORMANT <u>Mrs. Lynn Bear</u> Address <u>Rox Greenacres</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 404X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Thrombophlebitis</u> DUE TO (c) — | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease with congestive failure</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/29/67</u> , 19 <u>67</u> , to <u>5/29/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/29/67</u> , 19 <u>67</u> , and that death occurred at <u>4:20 PM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>D. R. Hess, Jr.</u> | | 22b. DATE SIGNED <u>5/29/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>D. R. Hess, Jr.</u> | |
| 22d. ADDRESS <u>SHADY GROVE, PA.</u> | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | 23b. DATE THEREOF <u>6/1/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 23d. LOCATION (City or Town) (County) (State) <u>Greencastle Pa.</u> | | |
| 24. FUNERAL DIRECTOR <u>R. E. Minnich</u> | | 25a. REC'D BY REGISTRAR <u>MAY 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07298

07277

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b D.O.A. | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital | | d. STREET ADDRESS 2377 Penna Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last MABEL SUTTON BOWEN | | 4 DATE OF DEATH Month Day Year May 5 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Apr 7 1909 |
| 9 AGE (In years last birthday) 58 | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b KIND OF BUSINESS OR INDUSTRY Fairchild | |
| 11 BIRTHPLACE (County & State, or foreign country) Verona Va. | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joshua Sutton | | 14. MOTHER'S MAIDEN NAME Mattie Daggy | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT Mr Archie L. Hinkle | | Address 2377 Penna Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 hr Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to 5 May , 19 67 , that (I) (we) last saw the deceased alive on 3 May 1967 , and that death occurred at 9:44 A.M. , from causes and on the date stated above | | | |
| 22a SIGNATURE John D. Wilson | | 22b. DATE SIGNED 11/767 | |
| 22c. PHYSICIAN'S NAME (Type) John D. Wilson | | 22d ADDRESS 580 Northern Avenue | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 5/7/67 | 23c NAME OF CEMETERY OR CREMATORY Verona E.U.B. Cemetery | 23d LOCATION (City or Town) (County) (State) Augusta Co Va. |
| 24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc | | 25a REC'D BY REGISTRAR MAY 19 1967 DATE | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 07293 | | 07273 | |
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE W. Va. b. COUNTY Doddridge | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Salem | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS RFD 2 | |
| 3. NAME OF DECEASED (Type or print) First KARL Middle NMN Last CARPENTER | | 4. DATE OF DEATH Month May Day 11 , Year 19 67 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-26-75 |
| 9. AGE (In years last birthday) 91 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11b. KIND OF BUSINESS OR INDUSTRY oil Co. | |
| 11c. BIRTHPLACE (County & State, or foreign country) Bridgeport, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William A. Carpenter | | 14. MOTHER'S MAIDEN NAME Ida Stout | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT W. G. Carpenter, Jefferson, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac failure 4-10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) benign prostatic hyperplasia - terminal uremia | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5-8 , 1967, to 5-10 , 1967, that (I) (we) last saw the deceased alive on 5-10 , 1967, and that death occurred at 1:54 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Crisp | | 22b. DATE SIGNED 5-11-67 | |
| 22c. PHYSICIAN'S NAME (Type) Jos C. CRISP MD | | 22d. ADDRESS 580 Northern Ave. Hagerstown | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | 23b. DATE THEREOF 5014-67 | 23c. NAME OF CEMETERY OR CREMATORY Salem I.O.O.F. Cem | 23d. LOCATION (City or Town) (County) (State) Salem, W. Va. |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR MAY 15 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1922

1922

1922

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

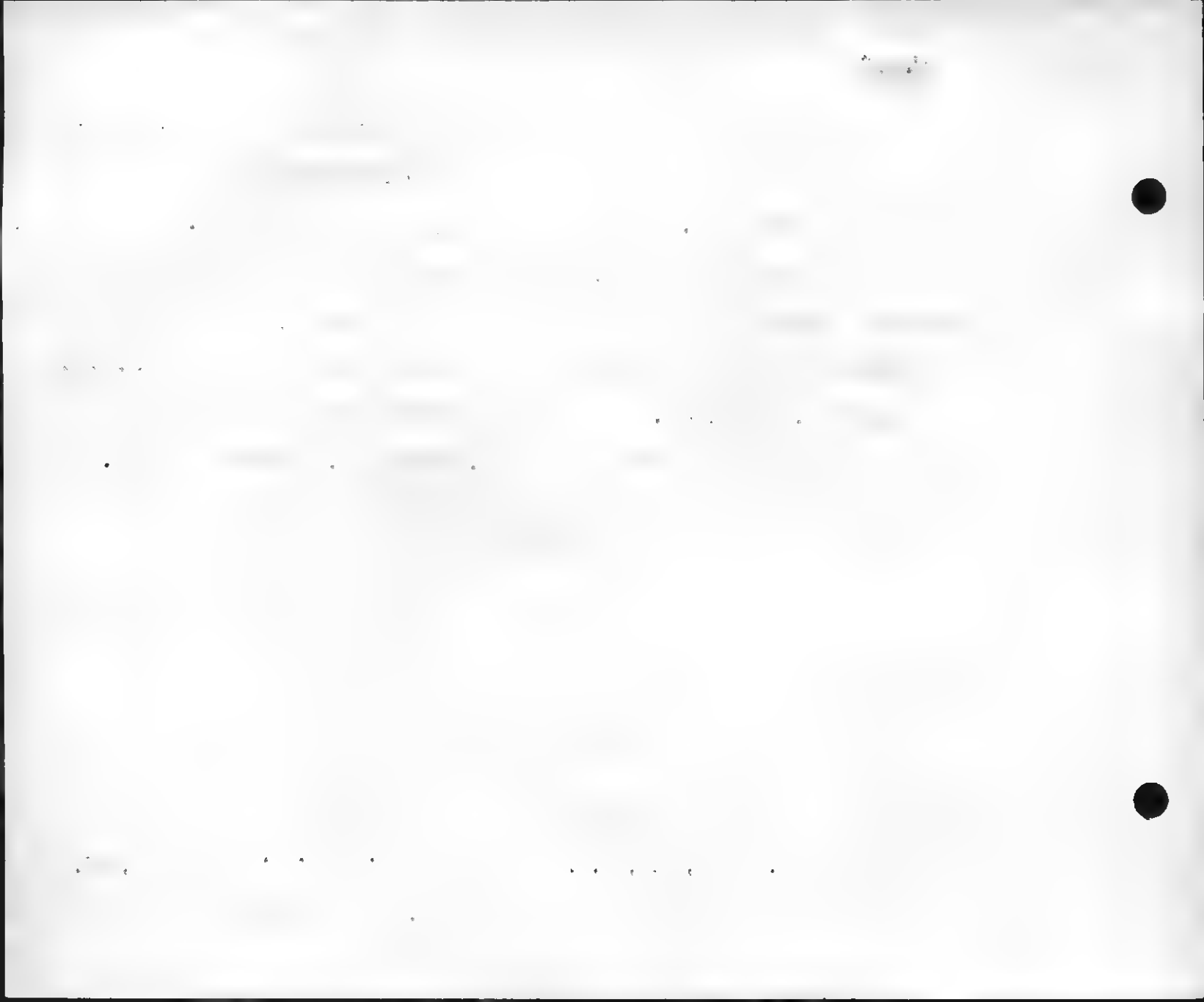
VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07300

07279

| | | | | | | | |
|---|---------------------------------|--|---|--|---|--|--|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b COUNTY WASHINGTON | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c LENGTH OF STAY IN b LIFE | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 331 S. MULBERRY ST. | | | | d STREET ADDRESS 331 S. MULBERRY ST. | | | |
| 3 NAME OF DECEASED (Type or print) First ROSTIE Middle VIRGINIA Last CARTER | | | | 4 DATE OF DEATH Month MAY Day 15 Year 19 67 | | | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9/11/1928 | | 9 AGE (In years last birthday) yrs 38 | 10 FINDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b KIND OF BUSINESS OR INDUSTRY HOME | | 11 BIRTHPLACE (State or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13 FATHER'S NAME JAMES WM. ALLEN SR. | | | | 14 MOTHER'S MAIDEN NAME MABEL SECORD | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO NONE | | 17 INFORMANT MR. THOMAS E. CARTER | | Address HAGERSTOWN MD. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis liver 551.0 DUE TO SPONTANEOUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe - with suspected hypoglycemia (c) Minutes | | | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic valvulopathy & Stenosis | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item B) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22. DATE SIGNED 5-16-67 | | | | DEPUTY MEDICAL EXAMINER W. J. Normant, Hagerstown, Md. | | | |
| 23a BURIAL (CREMATION REMOVAL) (Specify) | | 23b DATE THEREOF | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or town) (County) (State) | |
| BURIAL | | 5/18/67 | | REST HAVEN CEM. | | HAGERSTOWN WASH. MD. | |
| 24 FUNERAL DIRECTOR ADDRESS W. J. Normant, Hagerstown, Md. | | | | 25a REC'D BY REG. STRAR MAY 19 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film 6389 5/26/67 kk

07301

CERTIFICATE OF DEATH

07280

| | | | | | | | |
|--|---------------------------------|---|--|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institut an Res dence before adm ssion) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | c. LENGTH OF STAY IN 1b 60 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | | d. STREET ADDRESS 940B Lanvale St. | | e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last James Luther Comer, Sr. | | | | 4 DATE OF DEATH Month Day Year May 18 67 | | | |
| 5 SEX male | 6 COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH May 29, 1889 | | 9 AGE (In years last birthday) 78 yrs | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) conductor | | 10b. KIND OF BUSINESS OR INDUSTRY railroad | | 11 BIRTHPLACE (County & State, or foreign country) Luray, Virginia | | 12 CIT ZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David L. Comer | | | | 14. MOTHER'S MAIDEN NAME Emma J. Dawson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 705-10-8232 | | 17. INFORMANT Address Mrs Julia Comer, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus (Acquired) 344.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| 20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to May 18 , 19 67 , that (I) (we) last saw the deceased alive on May 18 , 19 67 , and that death occurred at 2 P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Charles Spencer M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Charles Spencer | | | | 22d. ADDRESS 145 S. Prospect St. Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 5-20-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Md. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR MAY 23 1967 | | 25b. REGISTRAR'S SIGNATURE g Charles Judge | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07302

CERTIFICATE OF DEATH

07281

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institut.an. Residence before admission) ✓ a. STATE Penna. b. COUNTY Franklin | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY in lb 2 wks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital | | | | d. STREET ADDRESS 346 Ringgold St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Paul Middle E. Last Cook | | | | 4. DATE OF DEATH Month May Day 11 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 31, 1896 | | 9. AGE (In years last birthday) 70 yrs | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co. | | 11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Peter S. Cook | | | | 14. MOTHER'S MAIDEN NAME Charlotte Kuhn | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 173-03-08341 | | 17. INFORMANT Mrs. Paul E. Cook | | Address Waynesboro, Penna. | |
| 18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER Right Lung 63X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis, Dec. 1966 to 1967 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 22, 1966 to May 11, 1967 , that (I) (we) last saw the deceased alive on May 10, 1967 , and that death occurred at 5:44 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE E. R. Laddizah | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5-11-1967 | |
| 22c. PHYSICIAN'S NAME (Type) E. R. Laddizah | | | | 22d. ADDRESS 600 N. KENNEDY RAYMOND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/14/1967 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City or Town) (County) (State) Greencastle, Franklin, Penna. | |
| 24. FUNERAL DIRECTOR Hallen G. Goss | | | | ADDRESS Waynesboro, Penna. | | 25a. REC'D BY REGISTRAR MAY 15 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

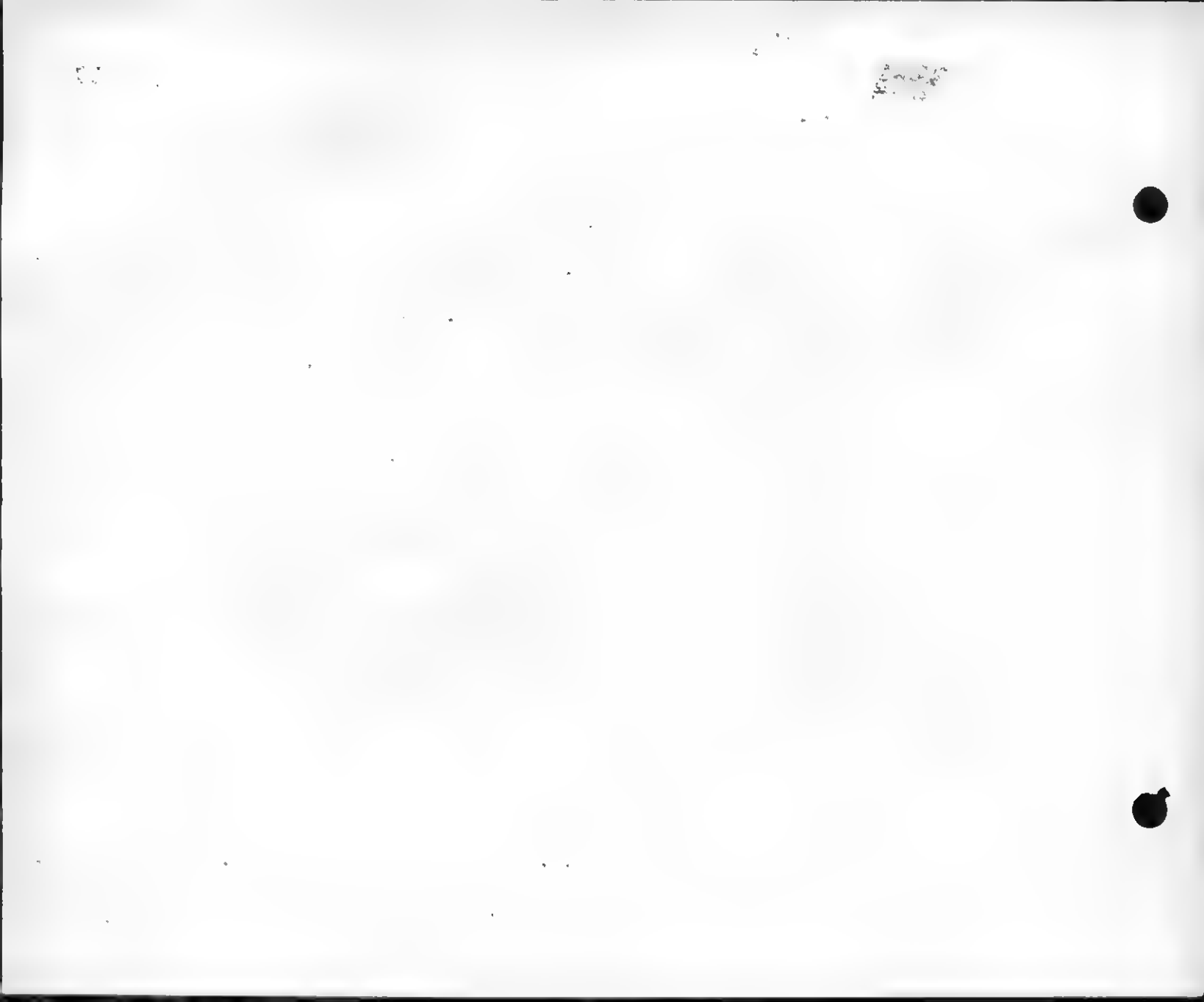
07303

CERTIFICATE OF DEATH

07282

| | | | | | | | |
|---|------------------------------------|--|---|--|---|--|-------------------------------|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c LENGTH OF STAY in 1b 40 YEARS | | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 474 NORTH POTOMAC STREET, | | | | d STREET ADDRESS 474 NORTH POTOMAC STREET, | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last KATHERINE N. CRAMER | | | | 4 DATE OF DEATH Month Day Year MAY 22, 19 67 | | | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH JAN. 11, 1909 | | 9 AGE (in years last birthday) 58 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER | | 10b KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS | | 11 BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME JAMES K. NOEL, SR. | | | | 14 MOTHER'S MAIDEN NAME LOLA PERKINS | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO. 220-26-7240 | | 17 INFORMANT MR. HARRY P. CRAMER, 474 NORTH POTOMAC ST. HAGERSTOWN, MARYLAND. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vasc. Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. | |
| | | | | | | 19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | | |
| 21. I certify that (1) this hospital attended the deceased from Jan. 10, 1965 to May 22, 1967 , that (1) we lost the deceased alive on May 22, 1967 , and that death occurred at 6:30 A.M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE <i>Lloyd A. Hoffman</i> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) DR. LLOYD A. HOFFMAN, M.D. | | | | 22d ADDRESS 214 NORTH POTOMAC ST. HAGERSTOWN, MD. | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF 5/24/67 | 23c NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | | 23d LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | | | |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | | | 25a REC'D BY REGISTRAR MAY 24 1967 | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07304

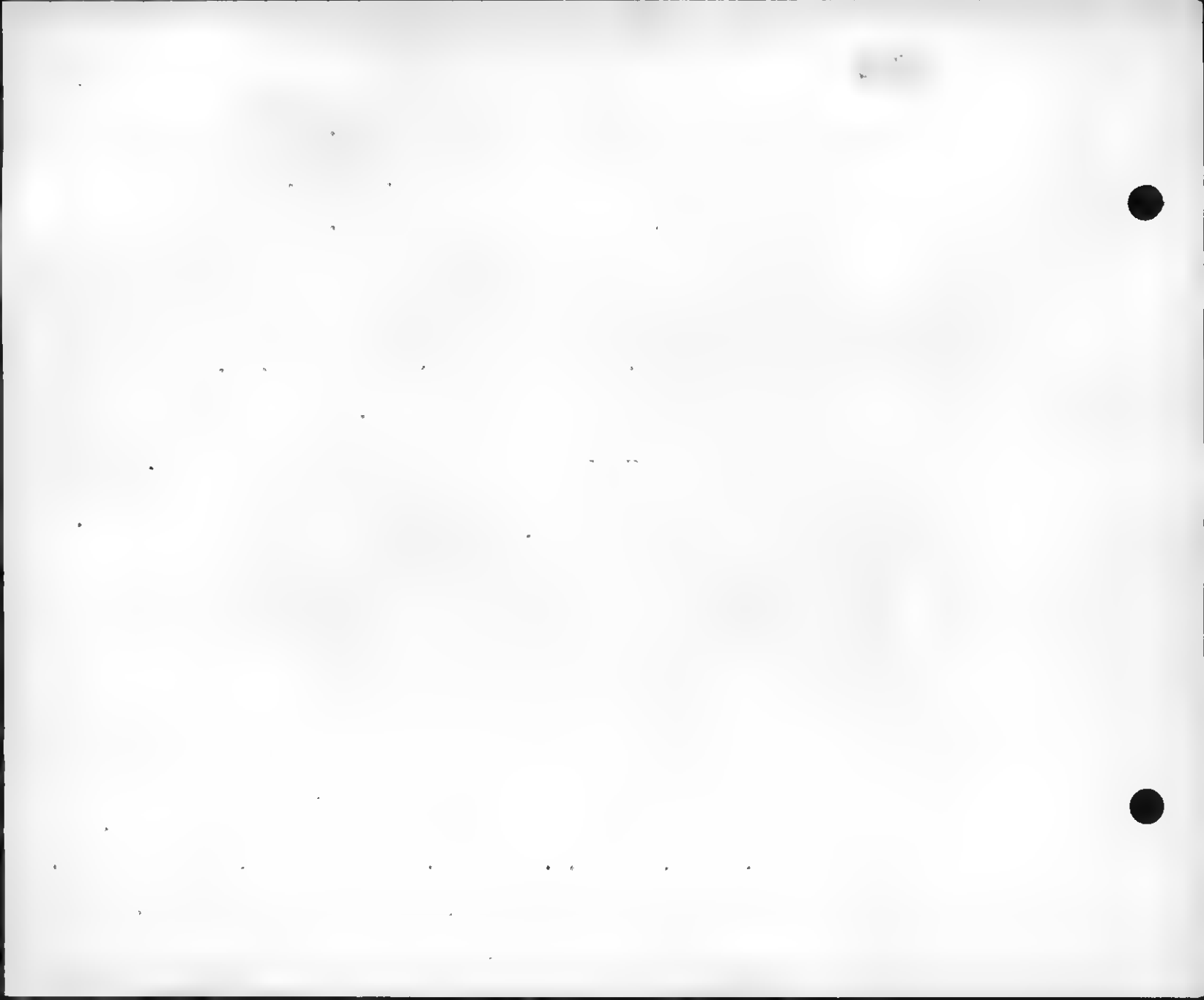
CERTIFICATE OF DEATH

07283

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before adm ssion) a STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c LENGTH OF STAY IN It <u>3 weeks</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Conv. Hosp.</u> | | d STREET ADDRESS <u>R.D.1</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Albert Russell Creager</u> | | 4 DATE OF DEATH <u>May 9, 1967</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>4/5/1892</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Shop Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mach. Mfg.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Mercersburg, Pa., R.1</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>David W. Creager</u> | | 14 MOTHER'S MAIDEN NAME <u>Susan L. Lightner</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u> | | 16 SOCIAL SECURITY NO <u>200-24-1638</u> | |
| 17. INFORMANT <u>Mrs. Albert R. Creager</u> | | Address <u>Pa., R. #1 St. Thomas.</u> | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease With</u> <u>Decompensation.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> years. |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1967</u> , to <u>May 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>6:30 M.</u> from causes and on the date stated above | | | |
| 22a SIGNATURE <u>Edward W. Ditto, III</u> | | 22b DATE SIGNED <u>May 11, 1967</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u> | | 22d ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b DATE THEREOF <u>5/12/67</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u> | 23d LOCATION (City or Town) (County) (State) <u>Mercersburg, Pa.</u> |
| 24. GENERAL DIRECTOR <u>Wm. L. Linger</u> | | 25a REC'D BY REGISTRAR <u>MAY 17 1967</u> | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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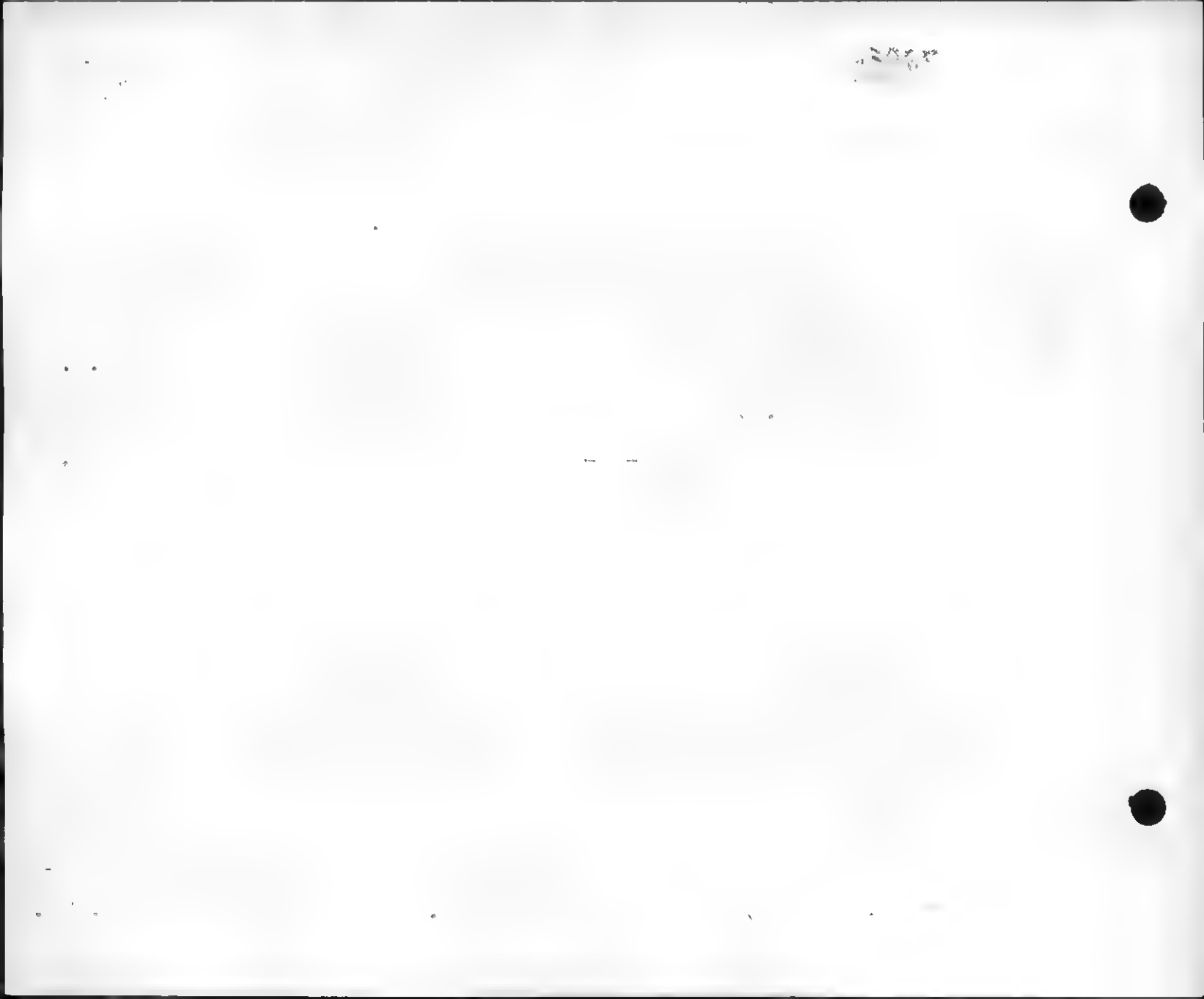
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07305

CERTIFICATE OF DEATH

07284

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 119 E. LEE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last CRIDER | | 4 DATE OF DEATH Month MAY Day 15 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/19/1900 |
| 9. AGE (In years last birthday) 66 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANER | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM L. CRIDER | | 14. MOTHER'S MAIDEN NAME NELLIE GRACE BAKER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 214-09-4885 | |
| 17. INFORMANT MRS. MARGARET L. CRIDER | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Adenocarcinoma of Rectum DUE TO (c) Uremia - Dehydrating Leukosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia - Dehydrating Leukosis | | | INTERVAL BETWEEN ONSET AND DEATH 2+ yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8 Feb. , 19 65 , to 15 May , 19 67 , that (I) (we) lost saw the deceased alive on 15 May , 19 67 , and that death occurred at 12 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. N. FENDER | | 22b. DATE SIGNED 16 May 1967 | |
| 22c. PHYSICIAN'S NAME (Type) W. N. FENDER | | 22d. ADDRESS 218 N. Potomac St., Hagerstown, Md. | |
| 23a. BURIAL CREMATION, REMOVAL BURIAL | 23b. DATE THEREOF 5/17/67 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD. |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR MAY 19 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07306

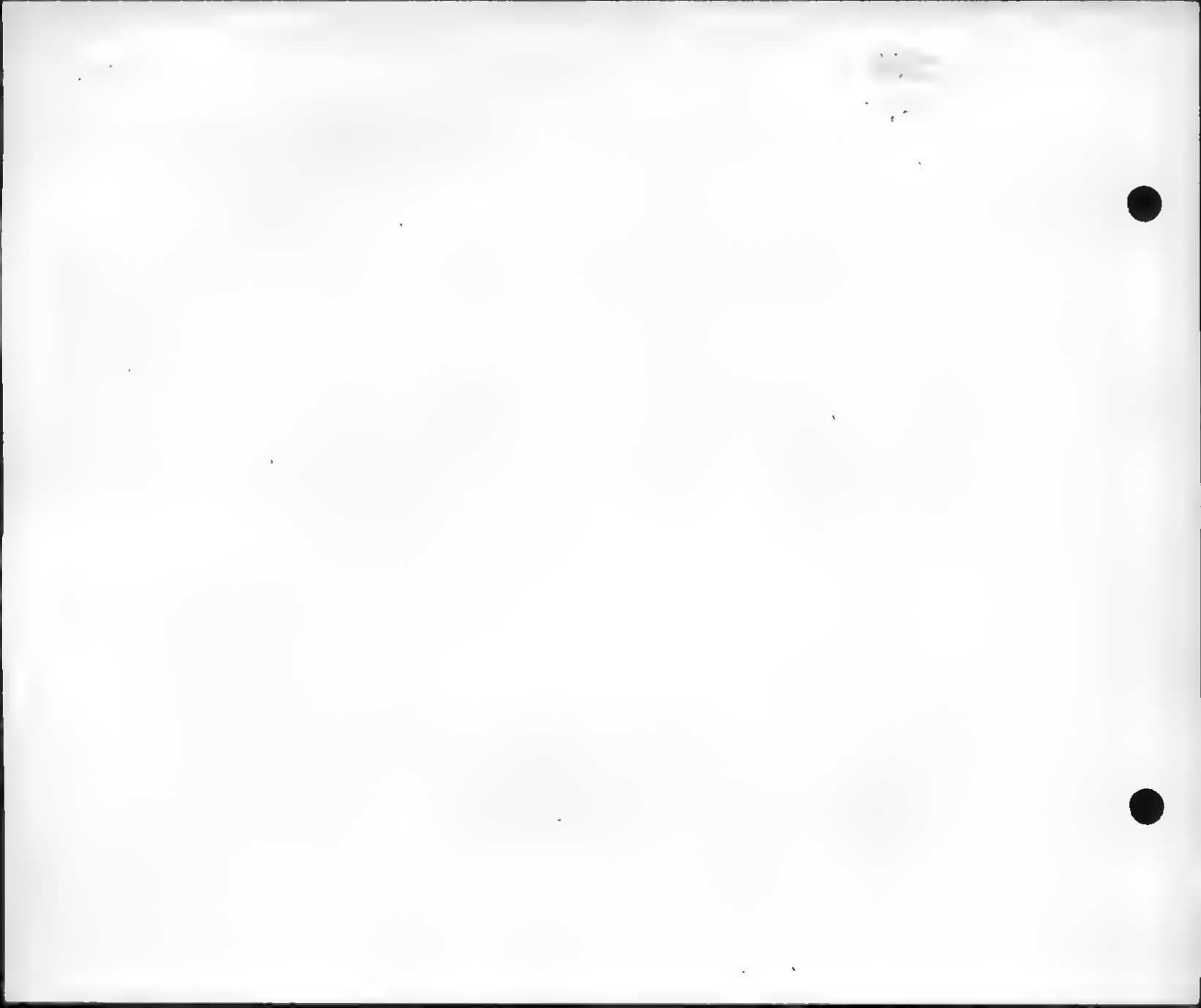
CERTIFICATE OF DEATH

07285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland | | | c. LENGTH OF STAY IN 1b Life time | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | d. STREET ADDRESS 55 W. Bethel Street | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Carrie Beatrice Davis | | | 4. DATE OF DEATH Month Day Year May 28 1967 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 10 1906 | | 9. AGE (in years last birthday) 61 yrs |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State or foreign country) Halfway, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME George T. Davis | | | 14. MOTHER'S MAIDEN NAME Harriet Watson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Address Leonard Davis 55 W. Bethel St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 5/12/67 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 2, 1967 to May 28, 1967 , that (I) (we) last saw the deceased alive on May 28, 1967 , and that death occurred at 1:15 p.m. from causes and on the date stated above | | | | | |
| 22a. SIGNATURE Donald E. Martin M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/29/67 |
| 22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D. | | | 22d. ADDRESS 418 N. Potomac St., Hagerstown, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF May 31 1967 | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Maryland | |
| 24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md. | | | 25a. REC'D BY REGISTRAR DATE JUN 2 1967 | | 25b. REGISTRAR'S SIGNATURE John R. Watson Jr. |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

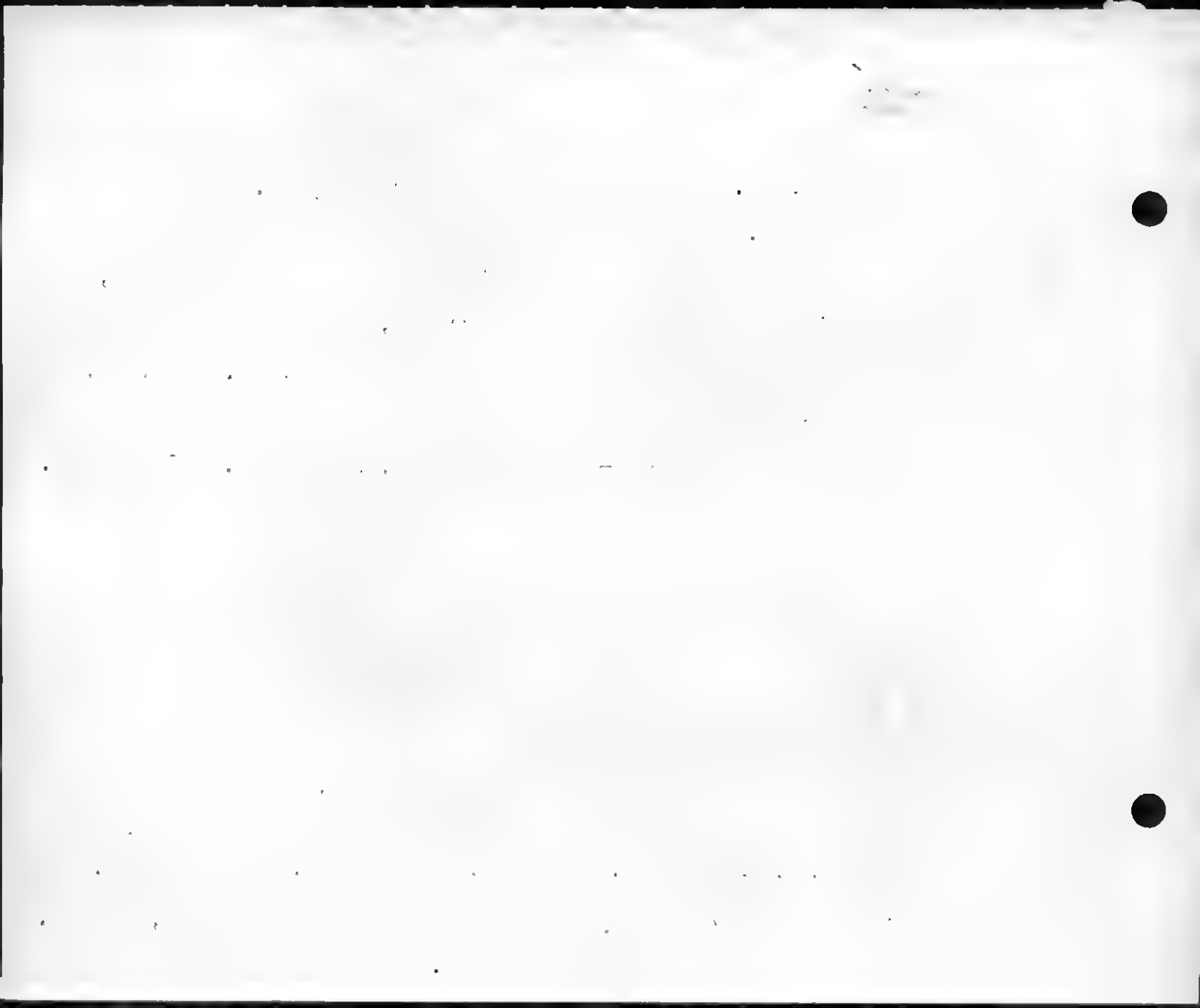
CERTIFICATE OF DEATH

07286

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. | | c. LENGTH OF STAY IN 1b 16 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital | | e. STREET ADDRESS Rural 2 | |
| 3. NAME OF DECEASED (Type or print) Helen May Dennis | | 4. DATE OF DEATH Month May Day 22 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 14, 1909 |
| 9. AGE (In years last birthday) 58 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY Home duties | |
| 11. BIRTHPLACE (County & State, or foreign country) Clear Spring, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Forsythe | | 14. MOTHER'S MAIDEN NAME Mollie Snyder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-48-5464 | |
| 17. INFORMANT George P. Dennis | | Address Rd. 2, Clspg. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Rheumatic Mitral Stenosis With Left Heart Failure. DUE TO (c) Recent | | | INTERVAL BETWEEN ONSET AND DEATH Instant |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 67 , to 5-22 , 19 67 , that (I) (we) last saw the deceased alive on 5-22 , 19 67 , and that death occurred at 2 P. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b. DATE SIGNED 5-23-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr. | | 22d. ADDRESS 215 W. Washington St., Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/24/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery | 23d. LOCATION (City or Town) (County) (State) Clear Spring, Md. |
| 24. FUNERAL DIRECTOR Margaret Rowland | | 25a. REC'D BY REGISTRAR MAY 26 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07308

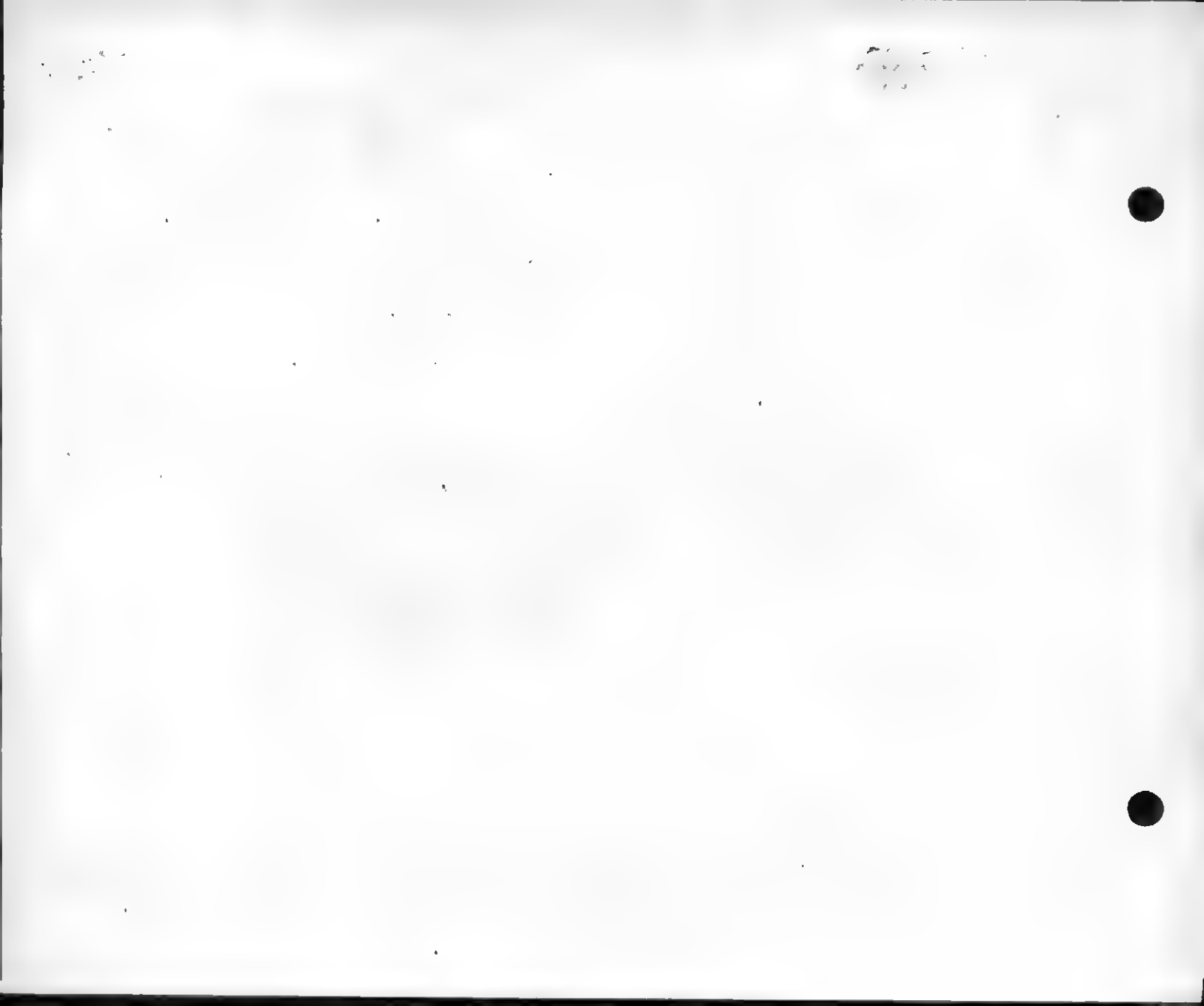
CERTIFICATE OF DEATH

07289

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 25 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 455 W. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Cleora Dorethea Easterday SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY housewife 11. BIRTHPLACE (County & State or foreign country) Mt. Airy, Md. 12. CITIZEN OF WHAT COUNTRY? USA | | 4. DATE OF DEATH Month May Day 23 Year 1967 9. AGE (In years last birthday) 68 13. FATHER'S NAME John W. McClelland 14. MOTHER'S MAIDEN NAME Agnes V. Barnes 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Leroy Easterday, Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost athero-sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRINCIPAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1 Day | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Hagerstown, Md. | | 21. I certify that (I) (this hospital) attended the deceased from May 23, 1967 to May 23, 1967 that (I) (we) last saw the deceased alive on May 23, 1967 , and that death occurred at 455 W. Washington St. from causes and on the date stated above. | |
| 22a. SIGNATURE J. H. Beachley 22c. PHYSICIAN'S NAME (Type) J. H. Beachley 22d. ADDRESS Hagerstown, Md. 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED 5/24/67 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-26-67 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. 25a. REC'D BY REGISTRAR MAY 31 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07308

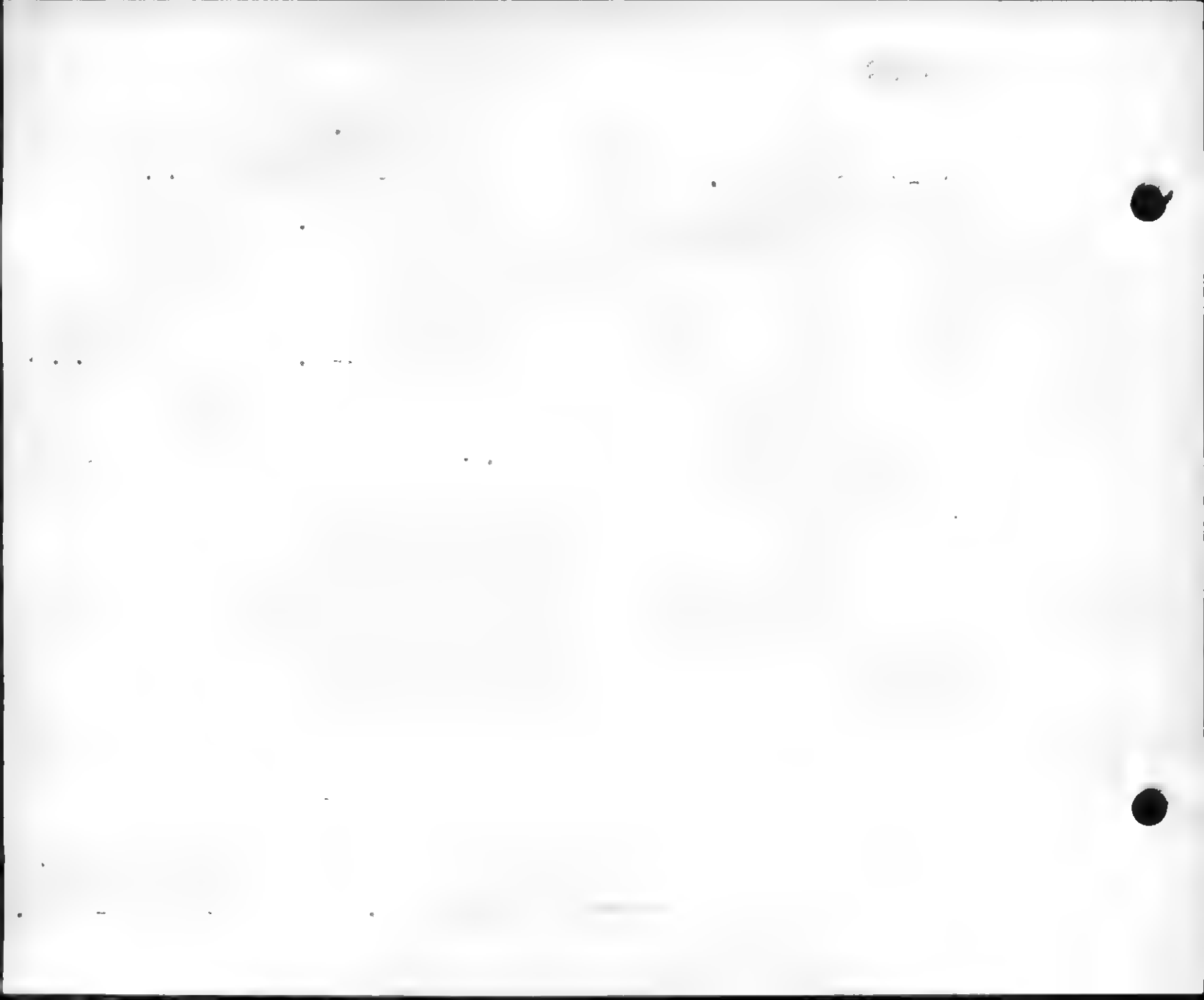
CERTIFICATE OF DEATH

07287

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Maugansville Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Chambersburg, R.R.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maugansville Mennonite Home</u> | | d. STREET ADDRESS <u>Greene Twp.</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE L. EBY</u> | | 4 DATE OF DEATH Month Day Year <u>MAY 23, 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/25/1870</u> |
| 9. AGE (n years last birthday) <u>96</u> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Franklin Co.-Pa.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>Henry Ebersole</u> | | 14 MOTHER'S MAIDEN NAME <u>Martha Lehman</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17 INFORMANT <u>Ira L. Eby</u> | | Address <u>R.R.#1, Chambersburg Pa. 17201</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) <u>(not hospital)</u> attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>May 23</u> , 19 <u>67</u> , that (1) <u>X</u> saw the deceased alive on <u>February</u> 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>E. W. Ditto, Jr.</u> | | 22b. DATE SIGNED <u>MAY 26, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>E. W. DITTO, JR. M.D.</u> | | 22d. ADDRESS <u>215 W. WASHINGTON ST. HAGERSTOWN, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>5/27/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chambersburg Mennonite Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Chambersburg-Franklin-Penna.</u> |
| 24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u> | | 25a. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles M. Rouzer</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

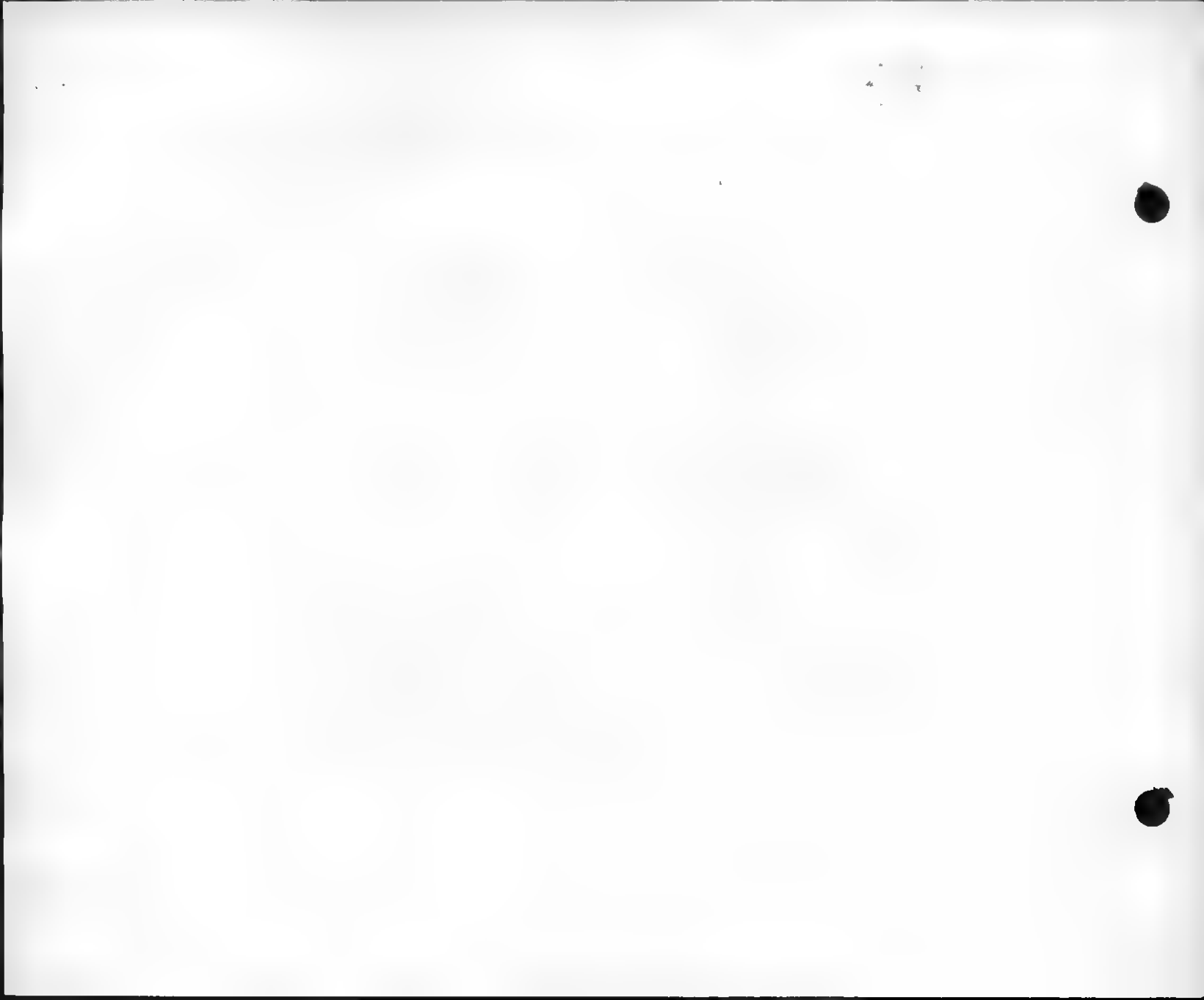
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07310

CERTIFICATE OF DEATH

07288

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro Rfd. 1 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney-Keedy Memorial Home | | d. STREET ADDRESS 7 CEDARWOOD RD. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Frances G. Fleagle | | 4 DATE OF DEATH Month Day Year May 12, 19 67 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH August 25, 1884 |
| 9. AGE (In years last birthday) yrs 82 | | 10. IF UNDER 1 YEAR Months Days Hours Min 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State or foreign country) W. VA. | | 12 CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME NEWTON GUNTHER | | 14. MOTHER'S MAIDEN NAME SUSAN TAYLOR | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17 INFORMANT ROBERT G. FLEAGLE | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) vascular disease DUE TO (c) 5 yrs | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1967 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 7:12 P.M. from causes and on the date stated above | | | |
| 22a. SIGNATURE G. W. H. Van | | 22b. DATE SIGNED May 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) G. W. H. Van | | 22d. ADDRESS Boonsboro, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5/16/67 | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE | 23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD |
| 24 FUNERAL DIRECTOR E. S. MACNABB | | 25a. REC'D BY REGISTRAR MAY 17 1967 | |
| ADDRESS 301 FREDERICK RD | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

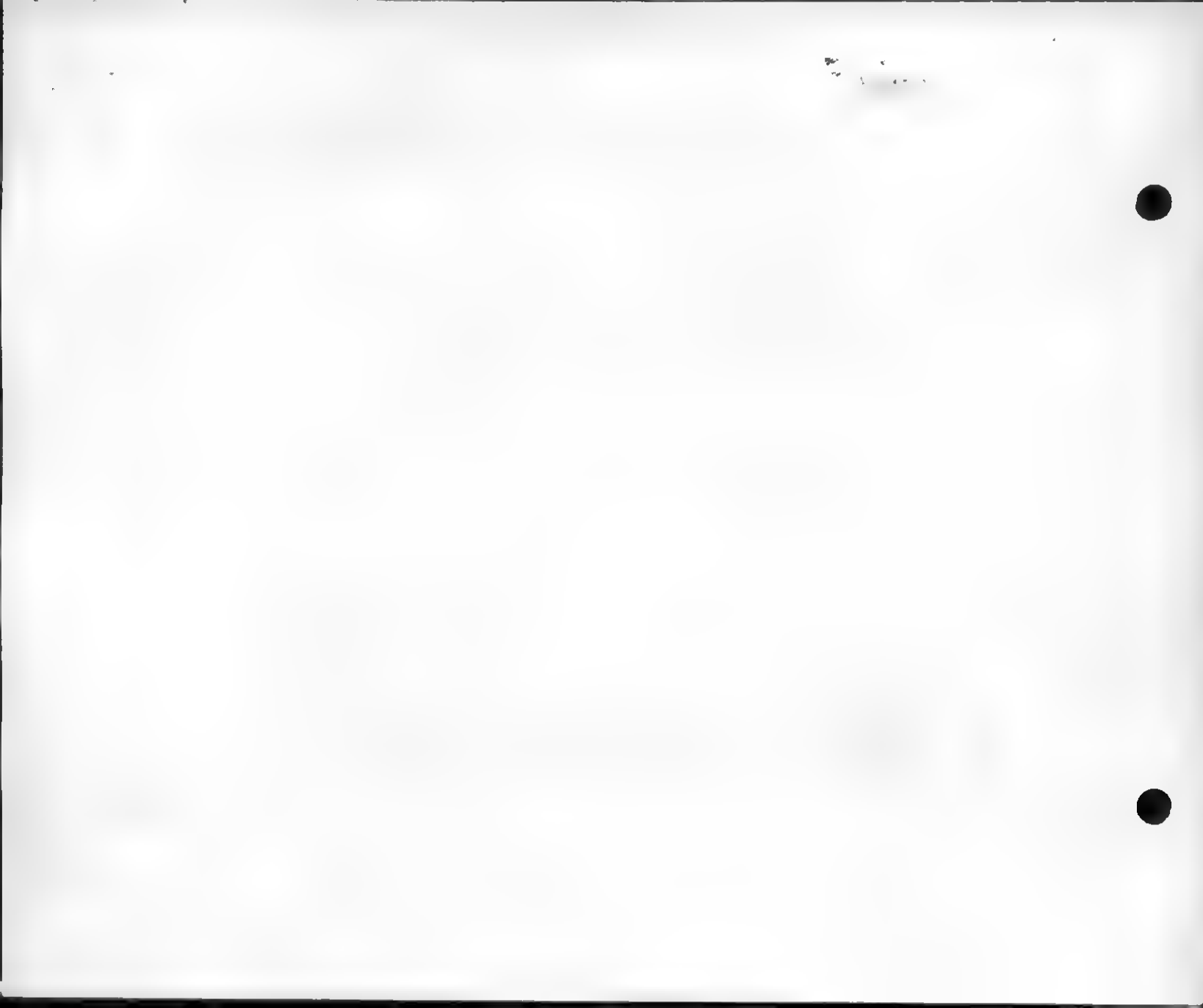
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07290

| | | | | | |
|---|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> c. LENGTH OF STAY IN 1b <u>65yrs.</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>237 Suter Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Joseph Gabriel French</u> First Middle Last 5 SEX <u>Male</u> 6 COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 4 DATE OF DEATH <u>May 5 1967</u> Month Day Year 8 DATE OF BIRTH <u>April 1 1898</u> 9. AGE (In years lost birthday) yrs. <u>69</u> IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Front Royal Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jack French</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u> | | 16. SOCIAL SECURITY NO. <u>212-14-7046</u> | | 17. INFORMANT Address <u>Nettie French 237 Suter Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 8 1963</u> , to <u>MAY 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 2 1967</u> , and that death occurred at <u>5:42 PM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED <u>6 MAY 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u> | | | | 22d. ADDRESS <u>218 N. Potomac St. Hagerstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>May 11 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | |
| 24. FUNERAL DIRECTOR <u>John R Watson</u> | | 25a. REC'D BY REGISTRAR <u>MAY 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| 23d. LOCATION (City or Town) (County) (State) <u>Gettysburg, Pa</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-5

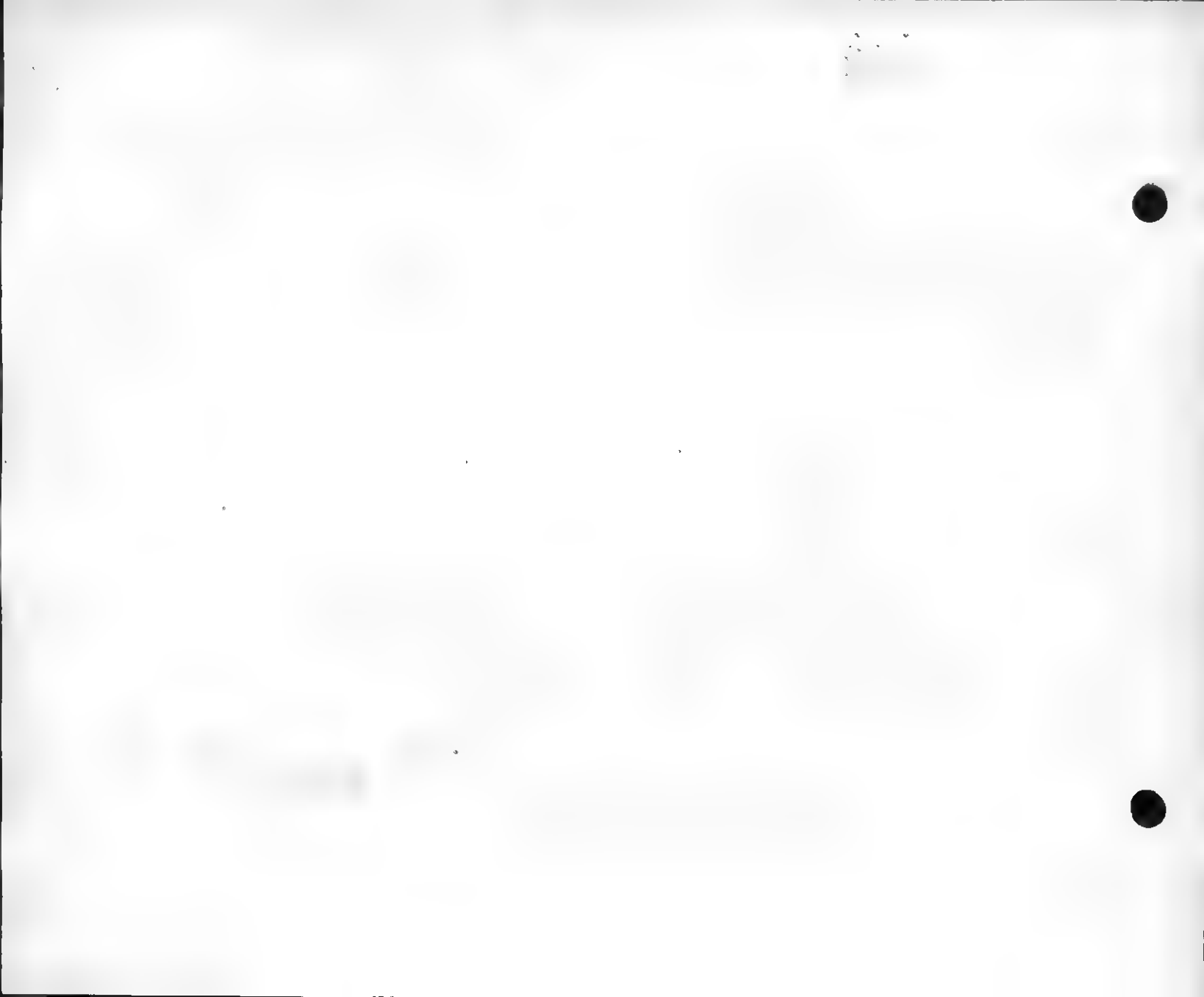
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07314

CERTIFICATE OF DEATH

07291

| | | | | | |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN 1b 50 YEARS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | d. STREET ADDRESS 412 WEST WASHINGTON ST. | | |
| 3. NAME OF DECEASED (Type or print) First LOGAN Middle ANTHONY Last GALLAGHER, SR. | | | 4. DATE OF DEATH Month MAY Day 30 Year 19 67 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 4, 1891 | 9. AGE (In years last birthday) 76 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY OWN TAVERN | | 11. BIRTHPLACE (County & State, or foreign country) ELBERTON, PENNSYLVANIA | |
| 13. FATHER'S NAME DAN S. GALLAGHER | | | 14. MOTHER'S MAIDEN NAME ANNIE R. (LAST NAME UNKNOWN) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 705-10-5341 | | 17. INFORMANT Wm. W. WASHINGTON ST. WILLIAM TERRY GALLAGHER, HAGERSTOWN, MARYLAND. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Esophageal varices (8 hrs.) 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Not Known | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (1) (the hospital) attended the deceased from 5/28, 1967 , to 5/29, 1967 , that (1) (we) last saw the deceased alive on 5/29, 1967 , and that death occurred at 7:30 A.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Arturo Riego M.D. | | 22b. DATE SIGNED MAY 31, 1967 | | 22c. PHYSICIAN'S NAME (Type) ARTURO RIEGO M.D. | |
| 22d. ADDRESS 159 W. WASHINGTON ST. HAGERSTOWN, MD. | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 6/2/67 | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MARYLAND. | | |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | 25a. REC'D BY REGISTRAR JUN 2 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07292

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived first institution Residence before admission) a STATE West Virginia b COUNTY Jefferson | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c LENGTH OF STAY IN 1b 12 weeks | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | e STREET ADDRESS RFD#2, Harpers Ferry | |
| 3 NAME OF DECEASED (Type or print) Edith ^{First} Geneva ^{Middle} Garrett ^{Last} | | 4 DATE OF DEATH Month 5 Day 7 Year 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 AGE (in years lost birthday) 54 yrs |
| 9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Line | | 9b KIND OF BUSINESS OR INDUSTRY Bookbinder | |
| 10a BIRTHPLACE (State or foreign country) Chestnut Hill, W.Va. | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME Humphrey Lee Wilt | | 14 MOTHER'S MAIDEN NAME Ida Eugene Pearl | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None | | 16 SOCIAL SECURITY NO 235-32-0902 | |
| 17 INFORMANT Mrs. Dolores Jenkins | | 18 ADDRESS RFD#2, Harpers Ferry, West Va. | |
| 19 INTERVAL BETWEEN ONSET AND DEATH 3-8-1962 | | | |
| 20 PART I CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brown tumor - Reticular DUE TO g43 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | | |
| 21 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1930 | | | |
| 22a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 22b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 23c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 23d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 23e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 23f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III M.D. EXAMINER'S NAME (Type) 217 W. WASHINGTON ST. HAG., MD. | | 22. DATE SIGNED 5-8-67 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 5/10/67 | 23c NAME OF CEMETERY OR CREMATORY Chestnut Hill Cemetery, Chestnut Hill W. Va. | 23d LOCATION (City or Town) (County) (State) |
| 24 FUNERAL DIRECTOR Donald Ecker | | 25 MAY 10 1967 DATE | |

THE UNIVERSITY OF CHICAGO

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

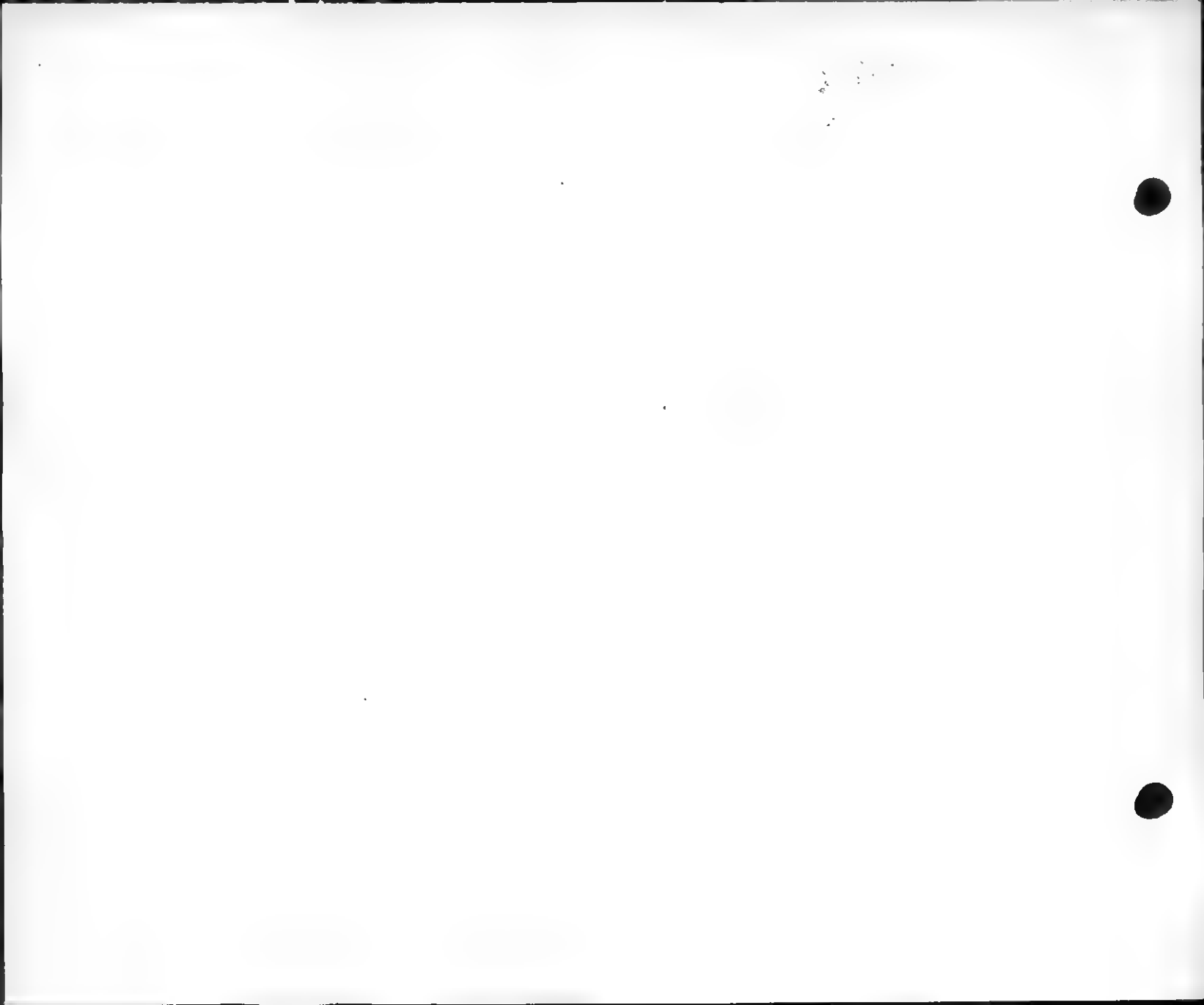
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07293

| | | | | | |
|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 'b' 66 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | d. STREET ADDRESS 355 Bryan Place | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last MERLE SCOTT GIBNEY | | | 4. DATE OF DEATH Month Day Year May 21 19 67 | | |
| 5. SEX male | 6. CO. OR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 24 1900 | 9. AGE (In years last birthday) 66 yrs | 10. F UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) florist | | 10b. KIND OF BUSINESS OR INDUSTRY greenhouse | | 11. BIRTHPLACE (State or foreign country) Hagerstown, Md | |
| 13. FATHER'S NAME Walter S. Gibney | | | 14. MOTHER'S MAIDEN NAME Elsie Conrad | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOC. A. SECURITY NO. 214-09-0340A | | 17. INFORMANT Address Frances Gibney, Hagerstown, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1) Brain stem damage DUE TO 2) Cerebral contusions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 3) Subarachnoid hemorrhage with basal and occipital skull fracture (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Undetermined Fell striking head on concrete. | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5/20 1967 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Green house | 20f. (City or town) (County) (State) Hagerstown Wash. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Howard N. Weeks</i> EXAMINER'S NAME (Type) Howard N. Weeks, M.D. | | CHIEF MED. CAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md. | | 5/22/67 22. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE THEREOF 5-24-1967 | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | | 23d. LOCATION (City or Town) (County) (State) Williamsport Md. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, MD | | 25a. REC'D BY REGISTRAR DATE MAY 26 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

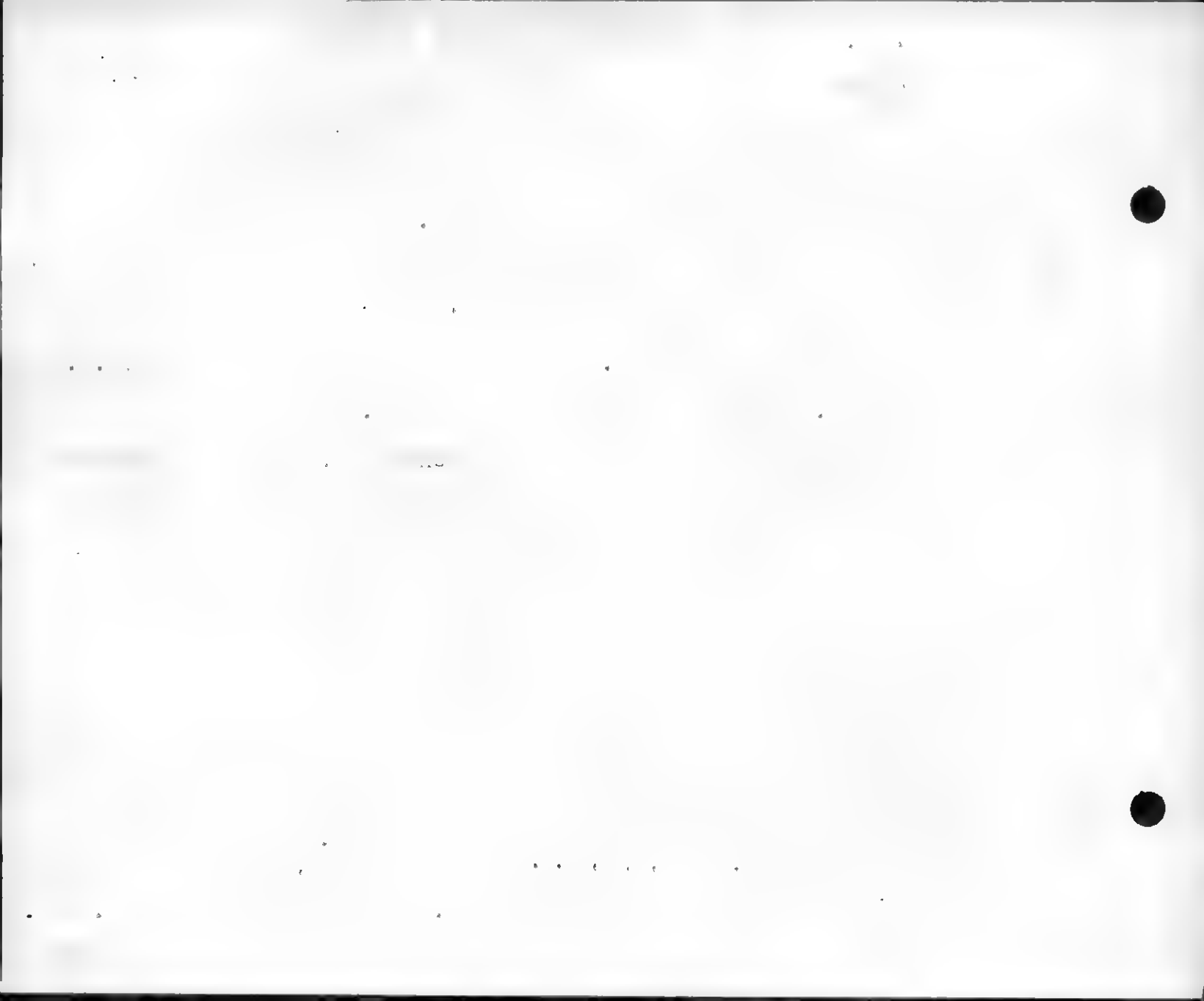
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07294

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c LENGTH OF STAY IN b LIFE | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d STREET ADDRESS RT.#6 HAGERSTOWN | |
| 3 NAME OF DECEASED (Type or print) First DALTA Middle RAE Last GRIMM | | 4 DATE OF DEATH Month MAY Day 24 Year 19 67 | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 11/5/1889 |
| 9 AGE (In years last birthday) 77 yrs | | 10 IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK | | 10b KIND OF BUSINESS OR INDUSTRY DEPT. STORE | |
| 11 BIRTHPLACE (County & State or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME IRVIN R. GRIMM | | 14. MOTHER'S MAIDEN NAME LILA V. BEARD | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO RT.#6 | |
| 17 INFORMANT MISS CARRIE P. GRIMM | | 18 ADDRESS HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized + DUE TO (c) Atherosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs 25 yrs |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aspiration of gastric Contents | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1963 to May 24, 1967 , that (I) (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 7:30 P. M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edward W. Ditto, III, M.D. | | 22b. DATE SIGNED 5-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. | | 22d. ADDRESS 217 W. Washington Street Hagerstown, Maryland | |
| 23a. BURIAL, CREMATION, REMAINS BURIAL | 23b. DATE THEREOF 5/27/67 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. |
| 24 FUNERAL DIRECTOR W.J. Norman, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR MAY 31 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, of this to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

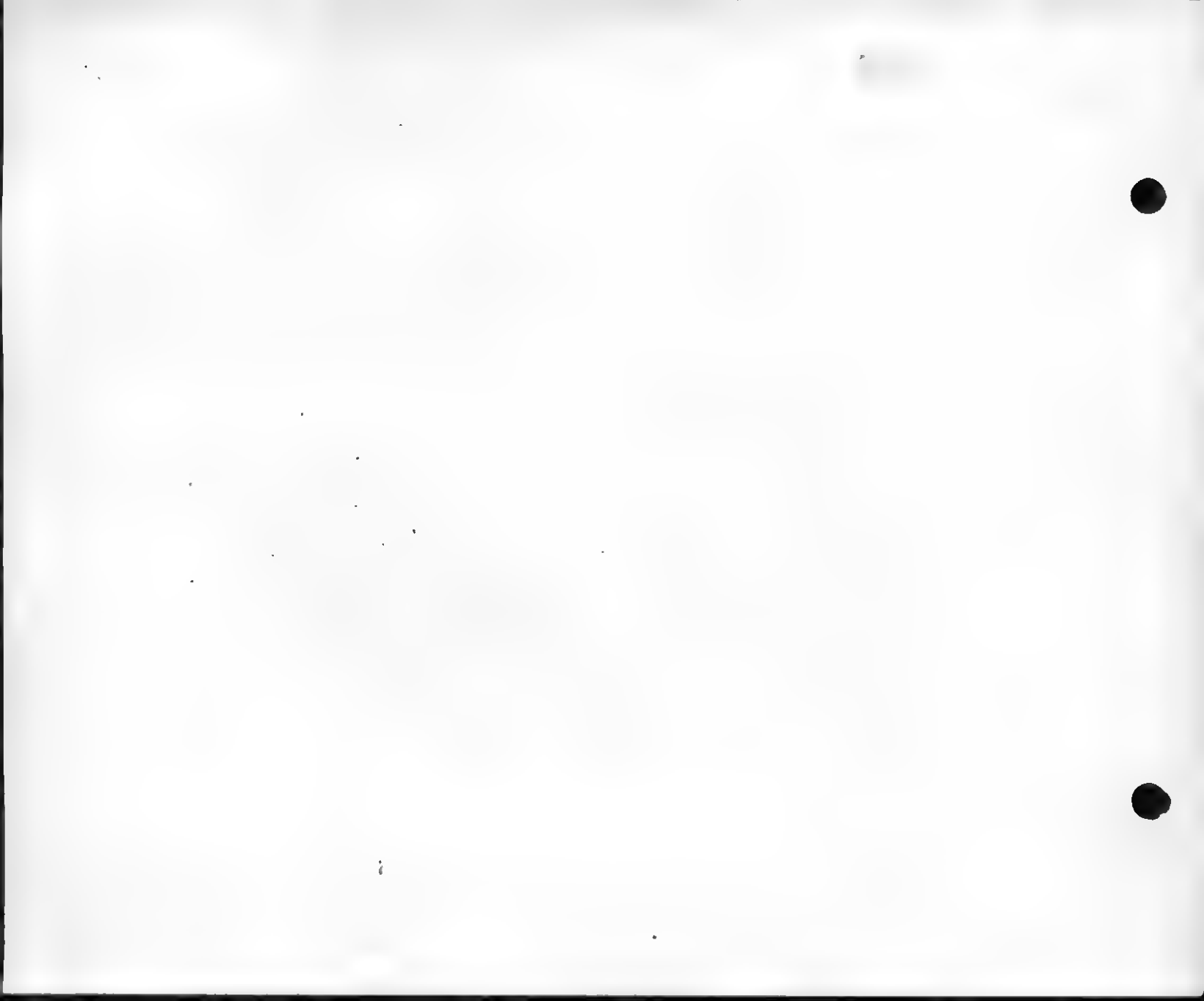
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07295

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN TB 2 Yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 238 So Mulberry St | | d. STREET ADDRESS 238 So Mulberry St | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DONALD LEE HARBAUGH | | 4. DATE OF DEATH Month Day Year May 10 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 19 1911 |
| 9. AGE (In years last birthday) 56 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY E.J. Pennell Co | |
| 11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Herman L. Harbaugh | | 14. MOTHER'S MAIDEN NAME Bertha M. Ausherman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No | | 16. SOCIAL SECURITY NO 414-09-7375 | |
| 17. INFORMANT Mrs Bertha M. Harbaugh | | Address 238 So Mulberry St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary atherosclerosis, severe; DUE TO (b) general atherosclerosis and DUE TO (c) Arterio sclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs 10-15 yrs yes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) ① Chronic Rheumatism ② Rib Fractures | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward W. Dillman III NAME (Type) 217 W. Washington St | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown Md | |
| 22. DATE SIGNED 5/11/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/12/67 | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md |
| 24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc | | 25a. REC'D BY REGISTRAR MAY 15 1967 DATE | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

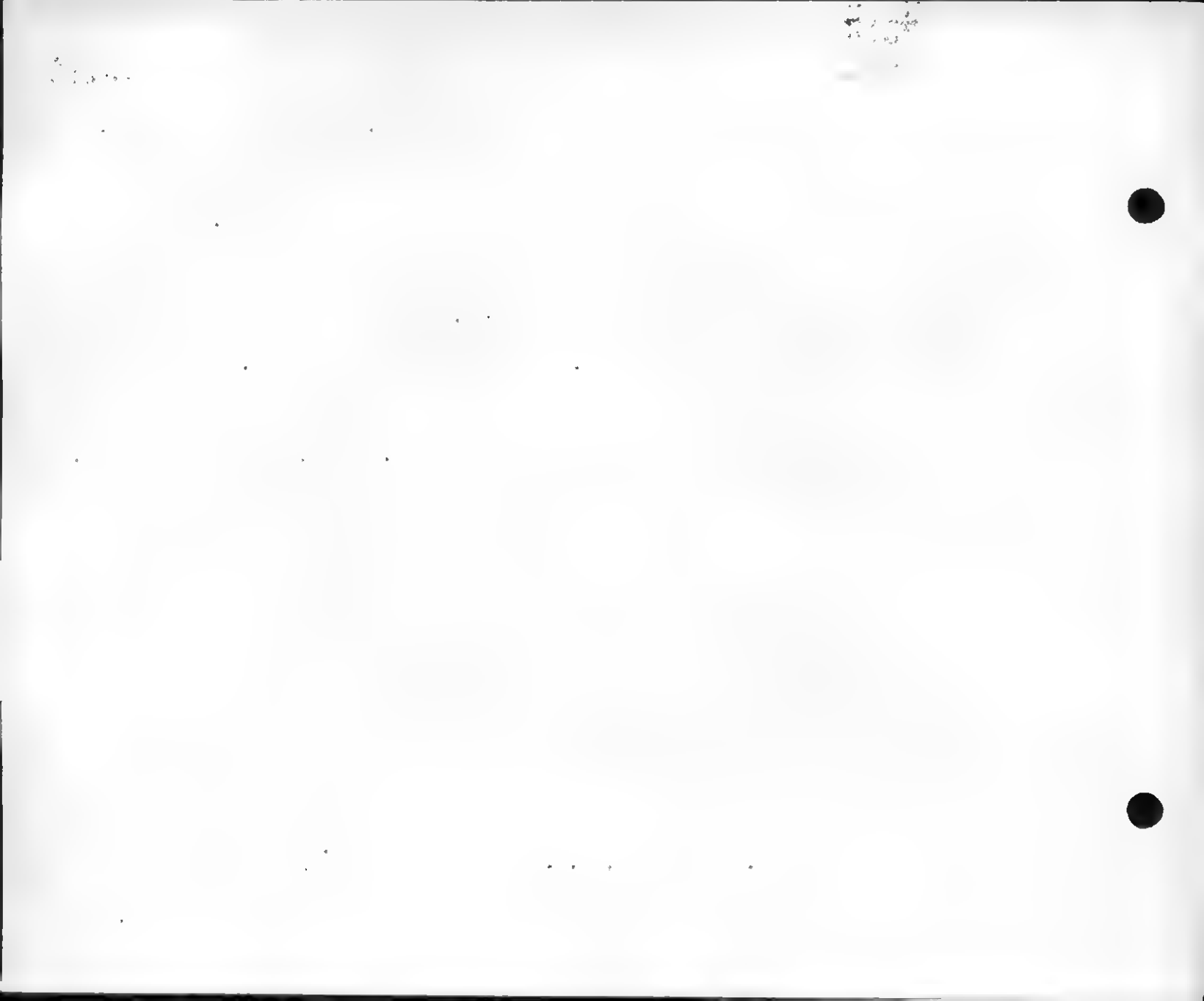
07317

CERTIFICATE OF DEATH

07296

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN TB 54 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | e. STREET ADDRESS 425 Clarendon Ave. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Margaret Alice Head | | 4 DATE OF DEATH Month Day Year May 27, 1967 | |
| 5 SEX female | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 20, 1899 |
| 9. AGE (in years last birthday) 67 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe mfg. | | 11 BIRTHPLACE (County & State, or foreign country) Timberville, Va. | |
| 12 CITIZEN OF WHAT COUNTRY? | | 13 FATHER'S NAME John Gordon | |
| 14. MOTHER'S MAIDEN NAME Mary E. Lloyd | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. 214-09-5671 | | 17. INFORMANT Address James W. Head, Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism Secondary DUE TO to cholecystectomy, cholelithiasis, DUE TO + Appendicitis DUE TO 586X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVAL BETWEEN ONSET AND DEATH 10 days 35 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Apr. 23, 1967 to May 27, 1967 , that (I) (we) last saw the deceased alive on May 27, 1967 , and that death occurred at 11:15 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edward W. Ditto, III, M.D. | | 22b. DATE SIGNED 5-29-67 | |
| 22c. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. | | 22d. ADDRESS 217 W. Washington Street Hagerstown, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-31-67 | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE JUN 1 1967 | |
| 25b. REGISTRAR'S SIGNATURE William J. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07318

07297

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hattie Wood Church Home</u> <u>2750 Va Ave, Wmspt, Md.</u> | | d. STREET ADDRESS <u>310 North Grant</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Hennenberger</u> | | 4 DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 30, 1881</u> |
| 9 AGE (In years last birthday) <u>85</u> yrs | | 10 UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Reid, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James B. Zimmerman</u> | | 14. MOTHER'S MAIDEN NAME <u>BARNHART</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>183-07-4150</u> | |
| 17. INFORMANT <u>Mark H. Wagoner, Capt</u> | | Address <u>2750 Va Ave Wmspt, Md.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive c.v. Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>10 yrs</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Aug 56</u> , 1965, to <u>5-1</u> , 1967, that (I) (we) last saw the deceased alive on <u>4-30</u> , 1967, and that death occurred at <u>7:00</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert P. Conrad</u> M.D. | | 22b. DATE SIGNED <u>5-1-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u> | | 22d. ADDRESS <u>Hagerstown, Md</u> | |
| 23a. BURIAL, CREMATION, or OTHER (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| <u>Burial</u> | <u>5/3/67</u> | <u>Green Hill Cem.</u> | <u>Waynesboro Pa.</u> |
| 24 FUNERAL DIRECTOR'S ADDRESS <u>A. E. Mummich - Greencastle, Pa</u> | | 25a. REC'D BY REGISTRAR <u>MAY 2 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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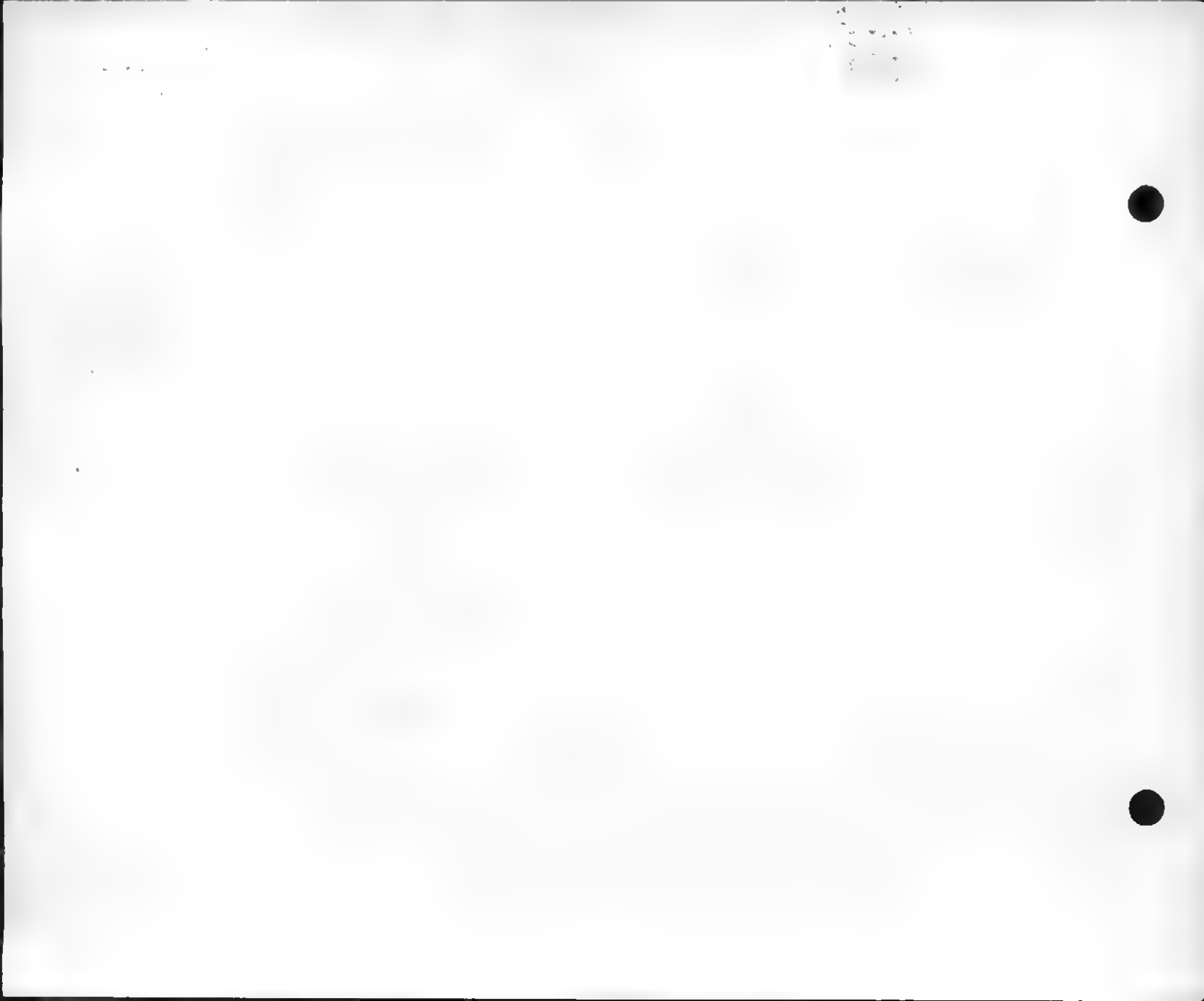
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07313

CERTIFICATE OF DEATH

07298

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN life LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | d. STREET ADDRESS 522 REYNOLDS AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MARY ELIZABETH HESS | | | | 4. DATE OF DEATH Month Day Year MAY 6, 19 67 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 19, 1901 | | 9. AGE (In years last birthday) 65 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY | | 10b. KIND OF BUSINESS OR INDUSTRY LAWYERS OFFICE | | 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL S. McCLAIN | | | | 14. MOTHER'S MAIDEN NAME ELLEN LUSHBAUGH | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 215-18-2624 | | 17. INFORMANT MISS JEANETTE McCLAIN, 522 REYNOLDS AVE. HAGERSTOWN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of gallbladder</i> DUE TO <i>with local extension to liver & pancreas</i> (b) <i>liver & pancreas</i> (c) <i>liver & pancreas</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Signal perforation stomach</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. AGE (If under 1 year, give month and day) OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | | 20h. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 13, 1967</i> , to <i>May 6, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 6, 1967</i> , and that death occurred at <i>1:02 P.M.</i> from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Lawrence L. Packer, Jr.</i> M.D. | | | | 22b. DATE SIGNED MAY 8, 1967 | | 22c. PHYSICIAN'S NAME (Type) DR. LAWRENCE L. PACKER, JR. | |
| 22d. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD. | | | | 22e. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD. | | 22f. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 5/9/67 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | | | 25. RECD BY REGISTRAR MAY 10 1967 | | 25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

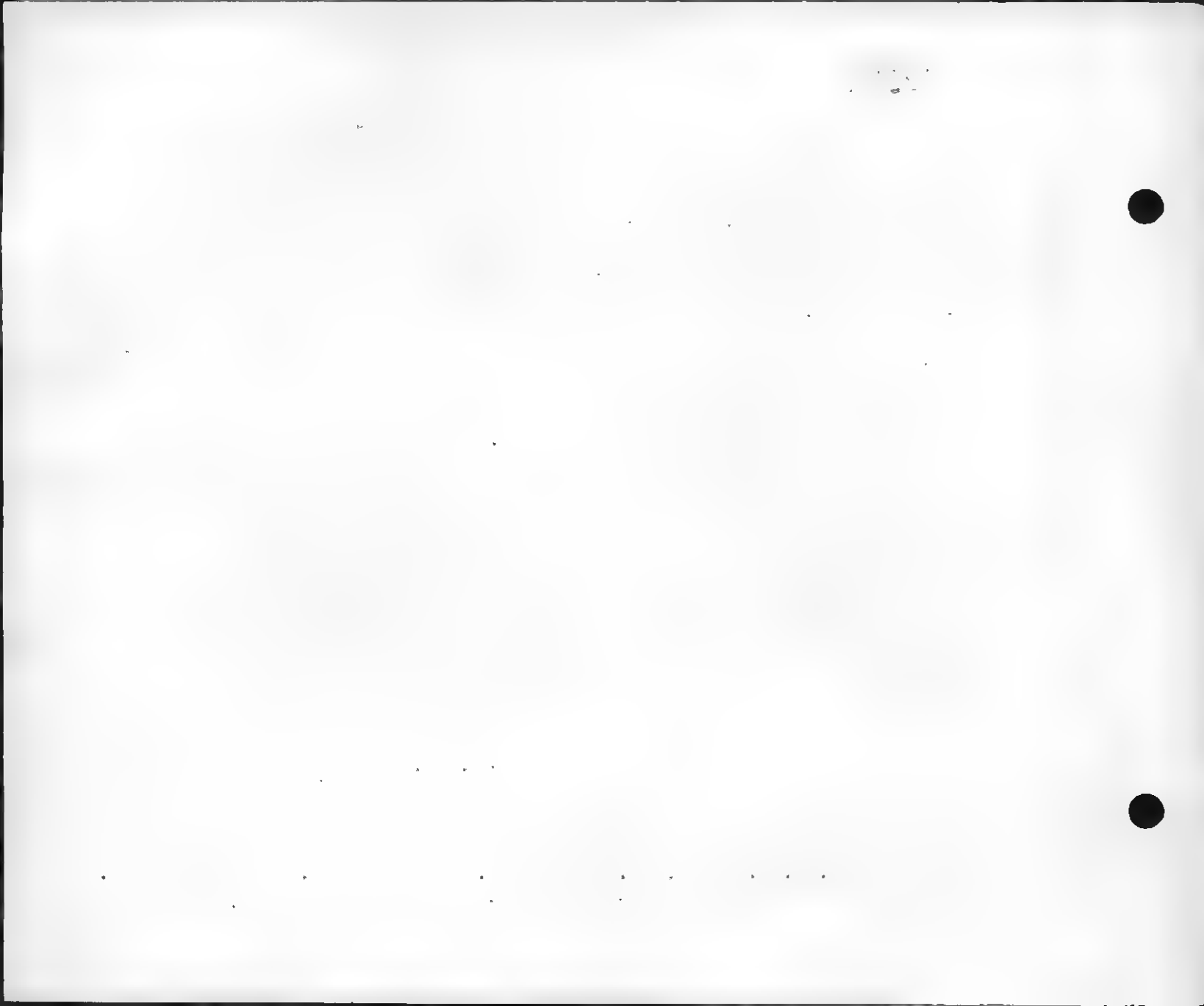
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07320

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Wash.</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u> | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maugansville, Md.</u> | | d STREET ADDRESS <u>Maugansville, Md.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BAER</u> Last <u>HORST</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 8, 1877</u> |
| 9. AGE (In years last birthday) yrs. <u>90</u> | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Baer</u> | | 14. MOTHER'S MAIDEN NAME <u>Susanna Horst</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT <u>S. Lester Horst</u> | | Address <u>Maugansville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> 4. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20, 1967</u> to <u>May 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1967</u> , and that death occurred at <u>10:30 pm</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u> | | 22b. DATE SIGNED <u>6-2-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u> | | 22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u> | 23b. DATE THEREOF <u>6/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u> | 23d. LOCATION (City or town) (County) (State) <u>near Cearfoss, Md.</u> |
| 24. FUNERAL DIRECTOR <u>A. E. Nimmich - Greencastle, Pa.</u> | | 25a. REC'D BY REGISTRAR <u>DATE JUN 5 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07321

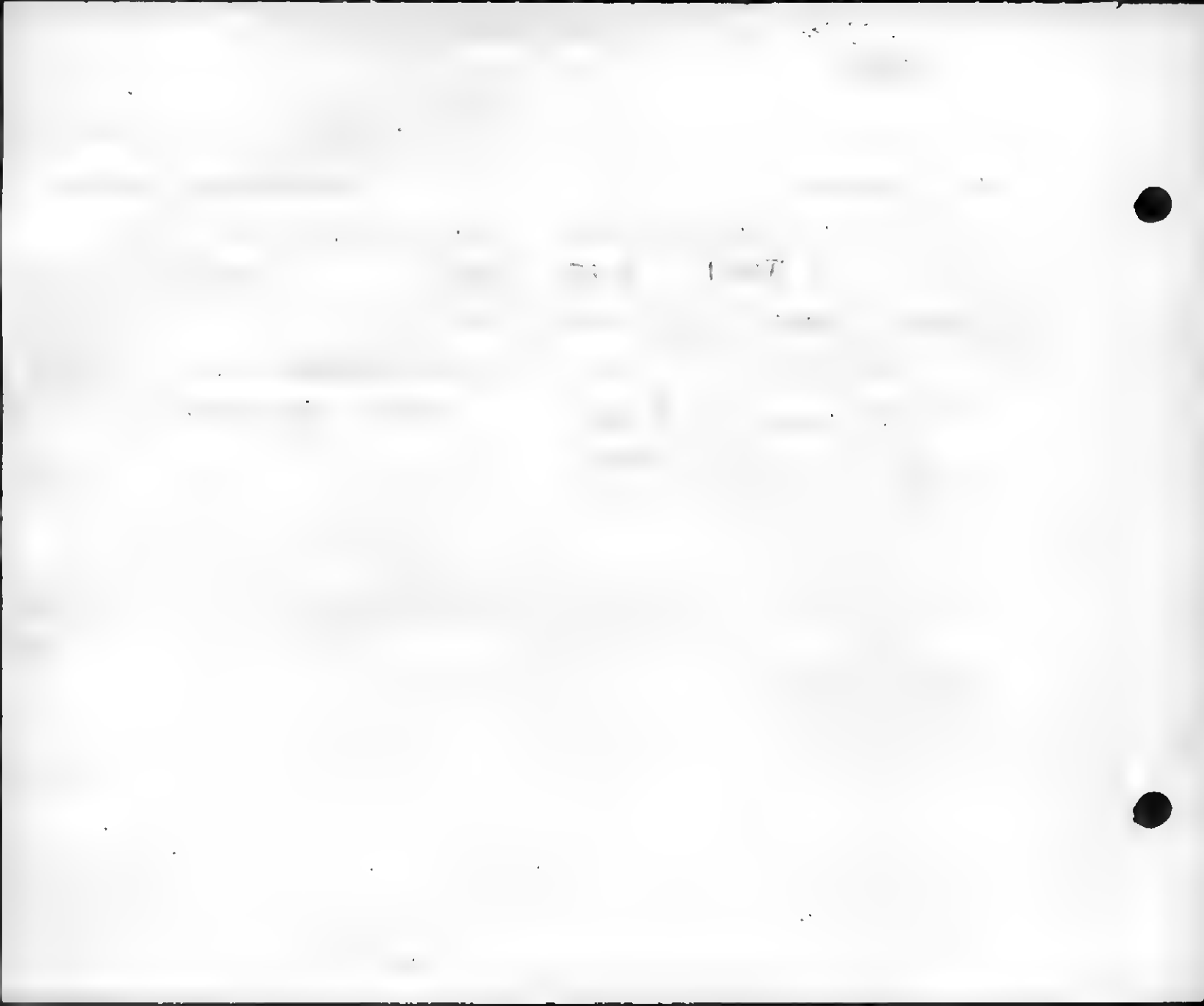
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07300

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a COUNTY <u>WASHINGTON</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>WASHINGTON</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt # 6, HAGERSTOWN, MD.</u> | | c LENGTH OF STAY IN 1b <u>6</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u> | | d. STREET ADDRESS <u>KING STREET</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>JODI SUE HORST</u> | | 4. DATE OF DEATH Month Day Year <u>MAY 15 1967</u> | |
| 5 SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>INFANT</u> | 8 DATE OF BIRTH <u>MAY 15, 1967</u> |
| 9. AGE (in years last birthday) <u>4</u> yrs | | IF UNDER 1 YEAR Months Days <u>4 10</u> | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON COUNTY, MD.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FRED LYNN HORST</u> | | 14. MOTHER'S MAIDEN NAME <u>SHARON SUE KEADLE</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16 SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT Address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PRIMARY ATELECTASIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MARKED IMMATUREITY Birth wt. 18oz 4 HRS.</u> DUE TO (c) <u>Prematurity</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>67</u> to <u>5-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>67</u> , and that death occurred at <u>3 45</u> P.M. from causes and on the date stated above. | | | |
| 22a SIGNATURE <u>Ronald E. Keyser</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>5/15/67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>RONALD E. KEYSER</u> | | 22d. ADDRESS <u>101 King St. HAGERSTOWN</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF <u>MAY 16, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u> | 23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN, MARYLAND</u> |
| 24 FUNERAL DIRECTOR <u>John B. Schaffer, adm</u> | | ADDRESS <u>Wash Co Hosp</u> | 25a REC'D BY REGISTRAR <u>MAY 22 1967</u> |
| | | 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

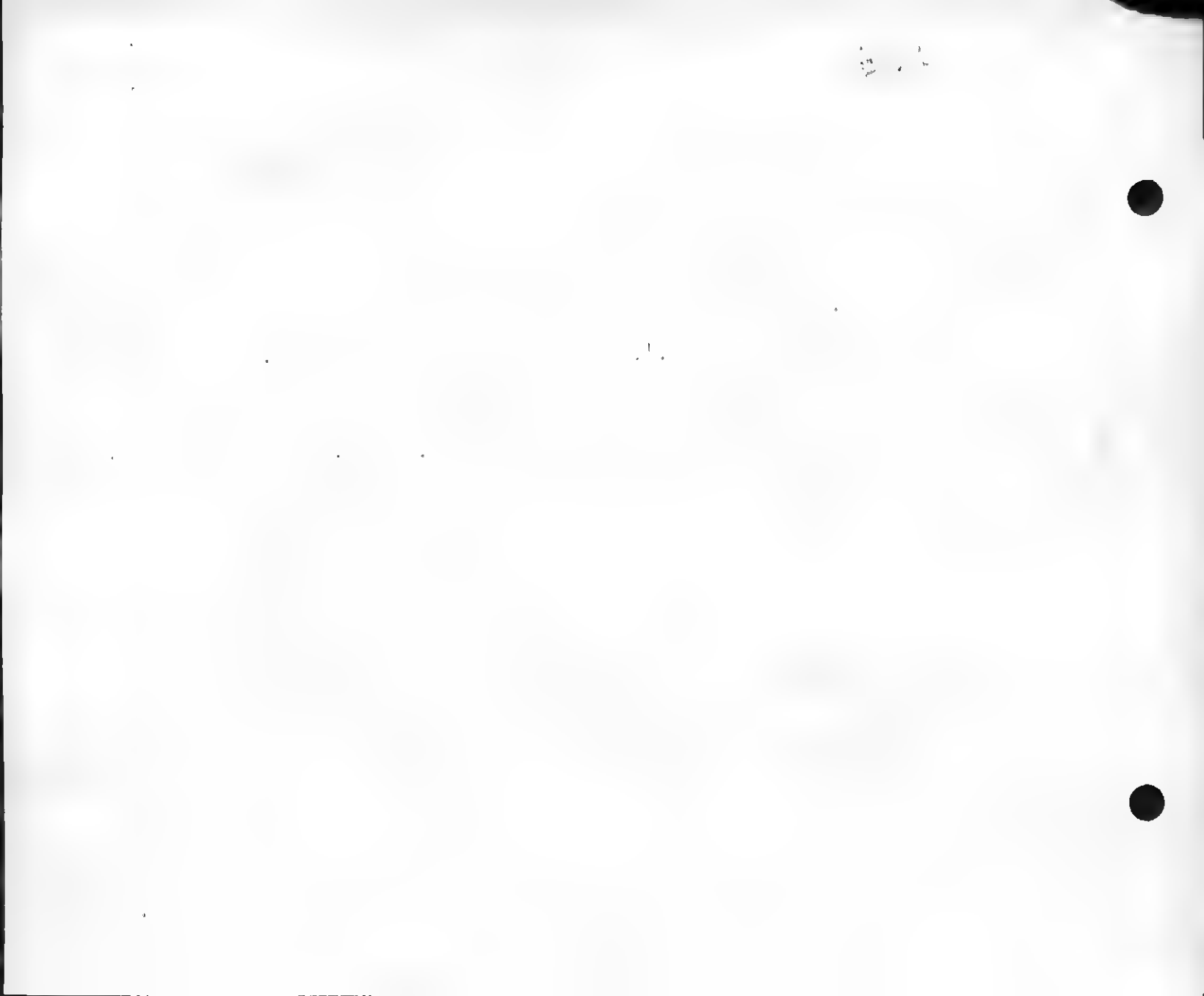
07322

07301

| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b rural Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS RFD 3 | |
| 3 NAME OF DECEASED (Type or print) First SARAH JANE Middle ELIZABETH Last HOSE | | 4 DATE OF DEATH Month May Day 18 Year 19 67 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7, 1929 |
| 9. AGE (In years last birthday) 38 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | |
| 11. BIRTHPLACE (County & State or foreign country) Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Ray Ford | | 14. MOTHER'S MAIDEN NAME Naomi Maugans | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-28-1053 | |
| 17. INFORMANT Fred T. Hose, Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subsiding embolus DUE TO acute myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) 3-4 weeks (c) | | INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 19 52 to May 19 67 that (I) (we) last saw the deceased alive on 5/18/67 19 67 , and that death occurred at 2:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John C. Morton | | 22b. DATE SIGNED 5/19/67 | |
| 22c. PHYSICIAN'S NAME (Type) John C. Morton | | 22d. ADDRESS Hagerstown, Md. | |
| 23a. B. RIAL CREMATION, REMOVAL (Type) burial | | 23b. DATE THEREOF 5-22-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or town) (County) (State) Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE MAY 23 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

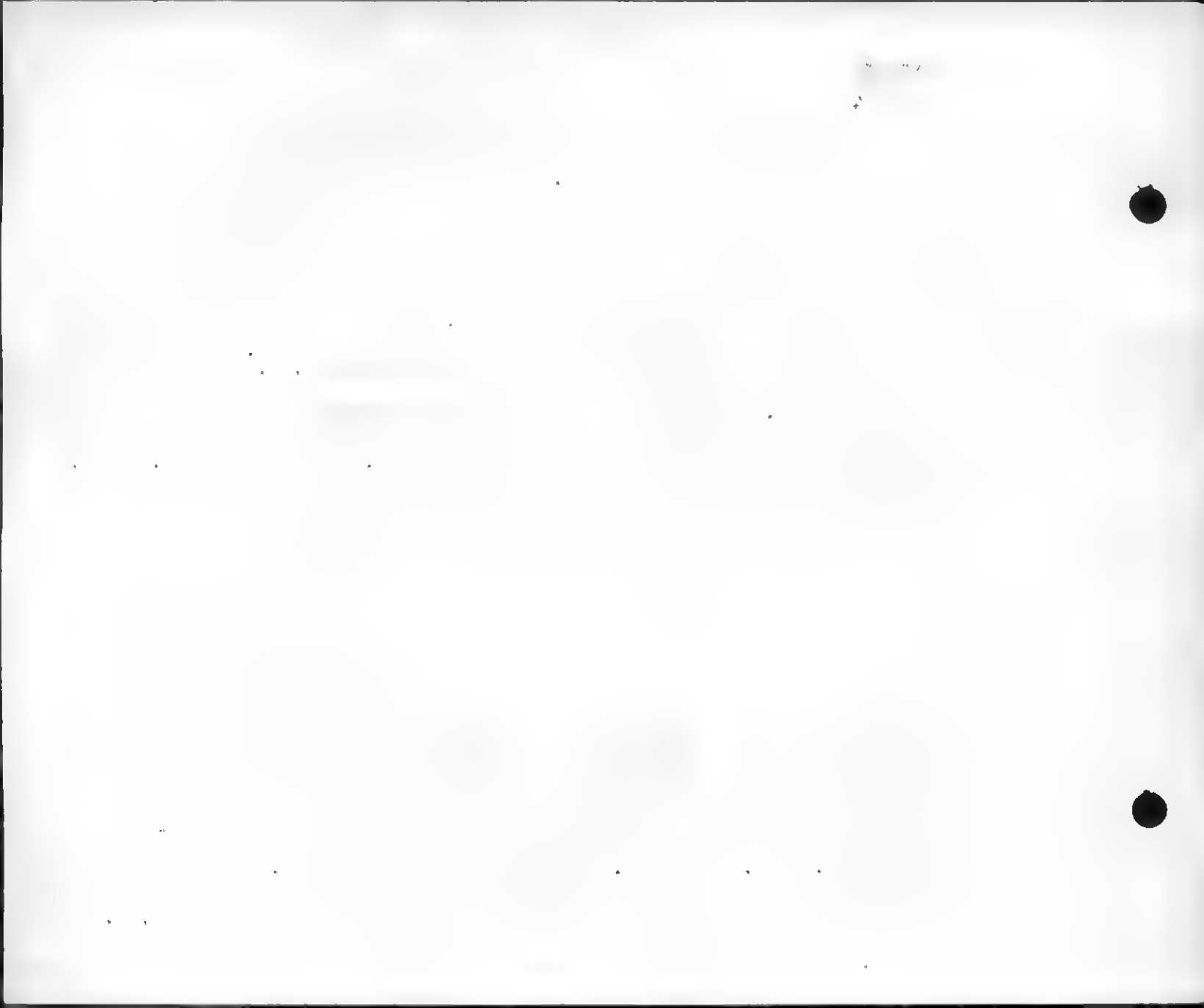
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07323

CERTIFICATE OF DEATH

08761

| | | | | | |
|---|--|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport | | c. LENGTH OF STAY IN 1b 3 Mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Rt. #1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport Sanitarium | | | d. STREET ADDRESS Dellinger Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First Lee Middle Hampton Last Howell | | | 4 DATE OF DEATH Month May Day 4 Year 19 67 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 3, 1877 | 9. AGE (In years last birthday) 89 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11 BIRTHPLACE (Country & State, or foreign country) Jefferson Co. Charles Town, W. Va. | |
| 13. FATHER'S NAME Joseph R. Howell | | | 12 CITIZEN OF WHAT COUNTRY? USA | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 219-54-0497 | | 17. INFORMANT George Howell, Williamsport, Rt. #1, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 1221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH Several days 5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-1-67 , 19 to 5-4 , 19 67 , that (I) (we) last saw the deceased alive on 5-4-1967 , and that death occurred at 5:15 P.M. , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE A. W. Ditto, Jr. | | | 22b. DATE SIGNED 5-5-67 | | 22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 5/8/67 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery |
| 23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash. Co., Md. | | | 23e. REC'D BY REGISTRAR JUL 10 1967 | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc., Hagerstown, Md. | | | 25a. REGISTRAR'S SIGNATURE Charles J. [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07324

CERTIFICATE OF DEATH

07302

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND. b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN lb 11 YEARS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d. STREET ADDRESS 331 BELVIEW AVENUE | |
| 3 NAME OF DECEASED (Type or print) First ROY Middle PAUL Last HUBER | | 4 DATE OF DEATH Month MAY Day 8 Year 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 27, 1890 |
| 9. AGE (in years last birthday) 76 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. US. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS | |
| 11 BIRTHPLACE (County & State or foreign country) FOUNTAIN CITY, WISCONSIN | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE HUBER | | 14. MOTHER'S MAIDEN NAME EMMA GEBHART | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 219-36-4728 | |
| 17. INFORMANT MRS. LINDA B. HUBER, HAGERSTOWN, MARYLAND. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Arteriosclerosis - brain DUE TO (c) Pulmonary Emphysema | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholecystitis | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from Nov 15 , 19 57 , to May 8 , 19 67 , that (I) (we) last saw the deceased alive on May 8 , 19 67 , and that death occurred at 3 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles A. Hoffman | | 22b. DATE SIGNED MAY 9, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) DR. LLOYD A. HOFFMAN, M.D. | | 22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5/10/67 | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | 25a. REC'D BY REGISTRAR MAY 12 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

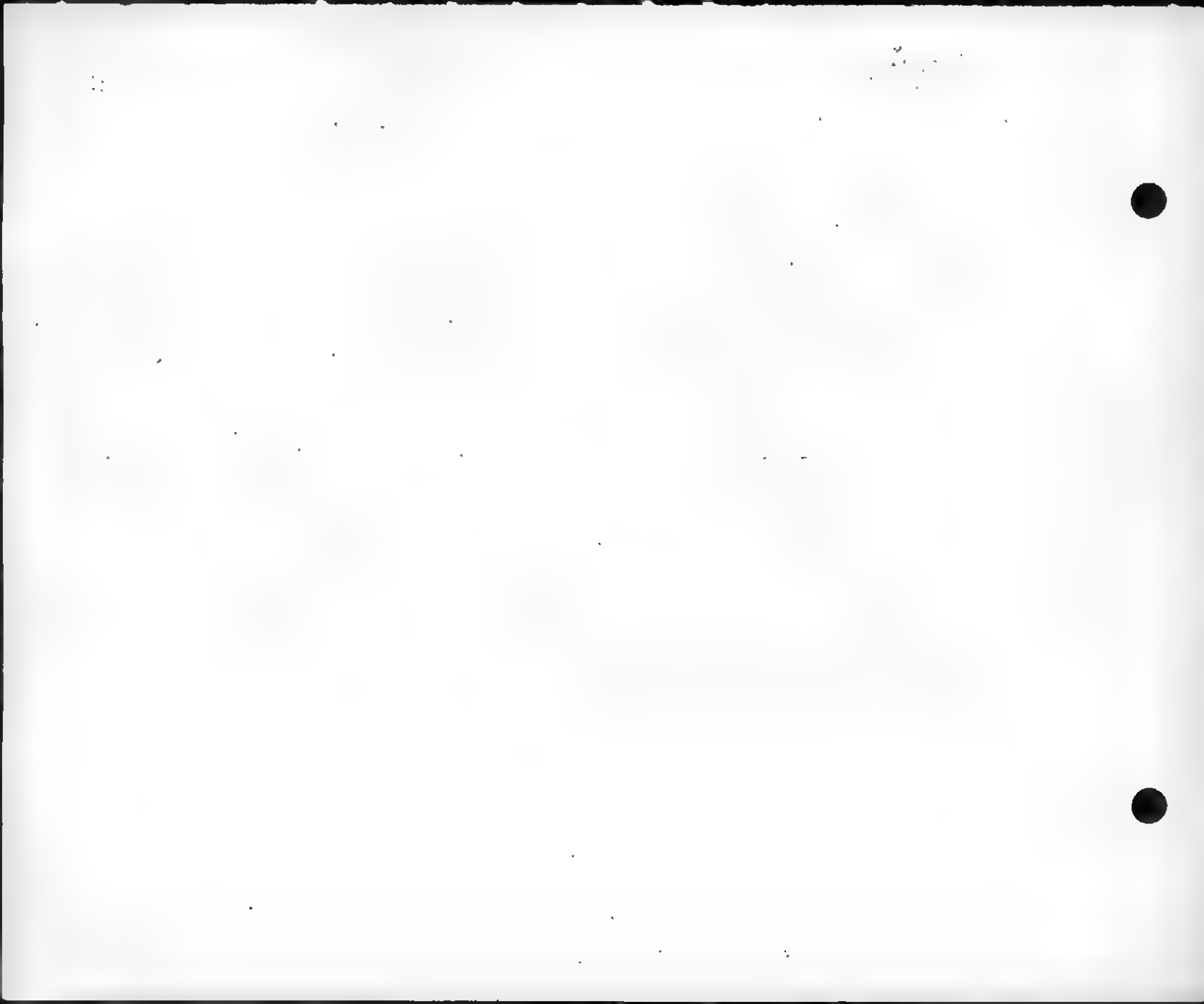


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07325
CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harpers Ferry RFD #1</u> | |
| c. LENGTH OF STAY IN 1b <u>1 week</u> | | d. STREET ADDRESS <u>Harpers Ferry RFD #1 W. Va</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ELIA</u> Middle <u>MARGARET</u> Last <u>ISEMINGER</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 27 1890</u> |
| 9. AGE (in years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Charles Drenner</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Kline</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-50-7748</u> | |
| 17. INFORMANT <u>Mr. H. Russell Iseminger</u> | | Address <u>Harpers Ferry RFD #1 W. Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolic Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-7-1965</u> to <u>5-15-1967</u> , that (I) (we) last saw the deceased alive on <u>5-15-1967</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Joseph Secomari</u> | | 22b. DATE SIGNED <u>5-16-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECOMARI</u> | | 22d. ADDRESS <u>800 N. D. R. Rd</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>May 18-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u> |
| 24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u> | | 25a. REC'D BY REGISTRAR <u>MAY 19 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07326

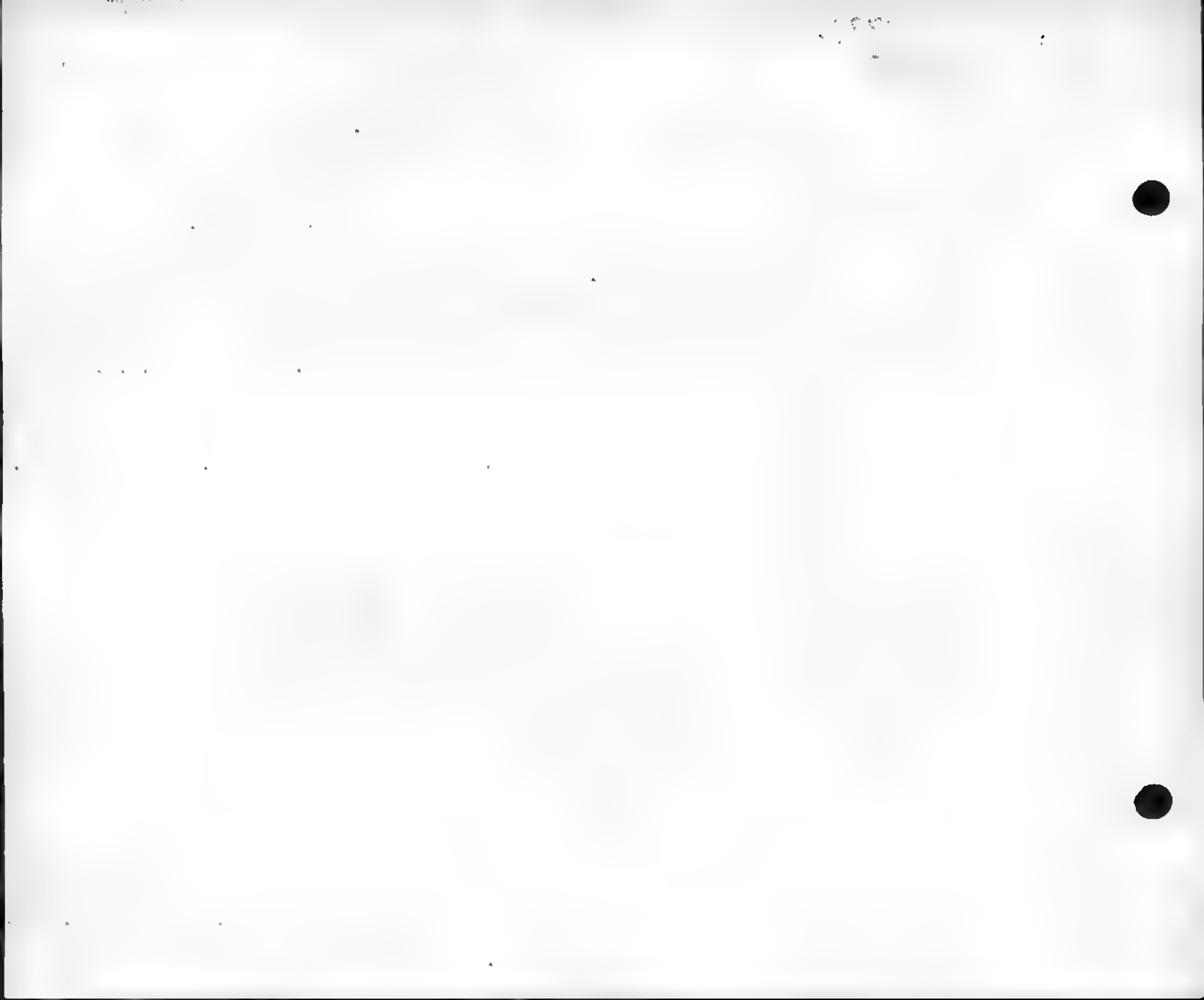
CERTIFICATE OF DEATH

07304

| | | | |
|--|-------------------------------------|--|---|
| 1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c LENGTH OF STAY IN 1b <u>10 Days</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | d STREET ADDRESS <u>312 W. Third St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>C.</u> Last <u>Kauffman</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1967</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>3/15/1901</u> |
| 9 AGE (In years last birth-day) <u>66</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Emmitsburg, Md.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>Albert Bowling</u> | | 14 MOTHER'S MAIDEN NAME <u>Gertrude Goulden</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO <u>173-03-0913B</u> | |
| 17 INFORMANT <u>Mr. Chester B. Kauffman Sr.,</u> | | Address <u>Waynesboro Pa.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon & metastases</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u> | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-6, 1964</u> , to <u>5/16, 1967</u> , that (I) (we) lost the deceased alive on <u>5/16, 1967</u> , and that death occurred at <u>6:30 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John H. Hurnbaker</u> | | 22b. DATE SIGNED <u>5/17/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HURNBAKER</u> | | 22d. ADDRESS <u>127 W. WASHINGTON ST. HAGERSTOWN MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>5/18/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u> | 23d. LOCATION (City or Town) (County) (State) <u>Waynesboro, Franklin Co., Pa.</u> |
| 24. FUNERAL DIRECTOR <u>Walter J. Hove</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>MAY 19 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

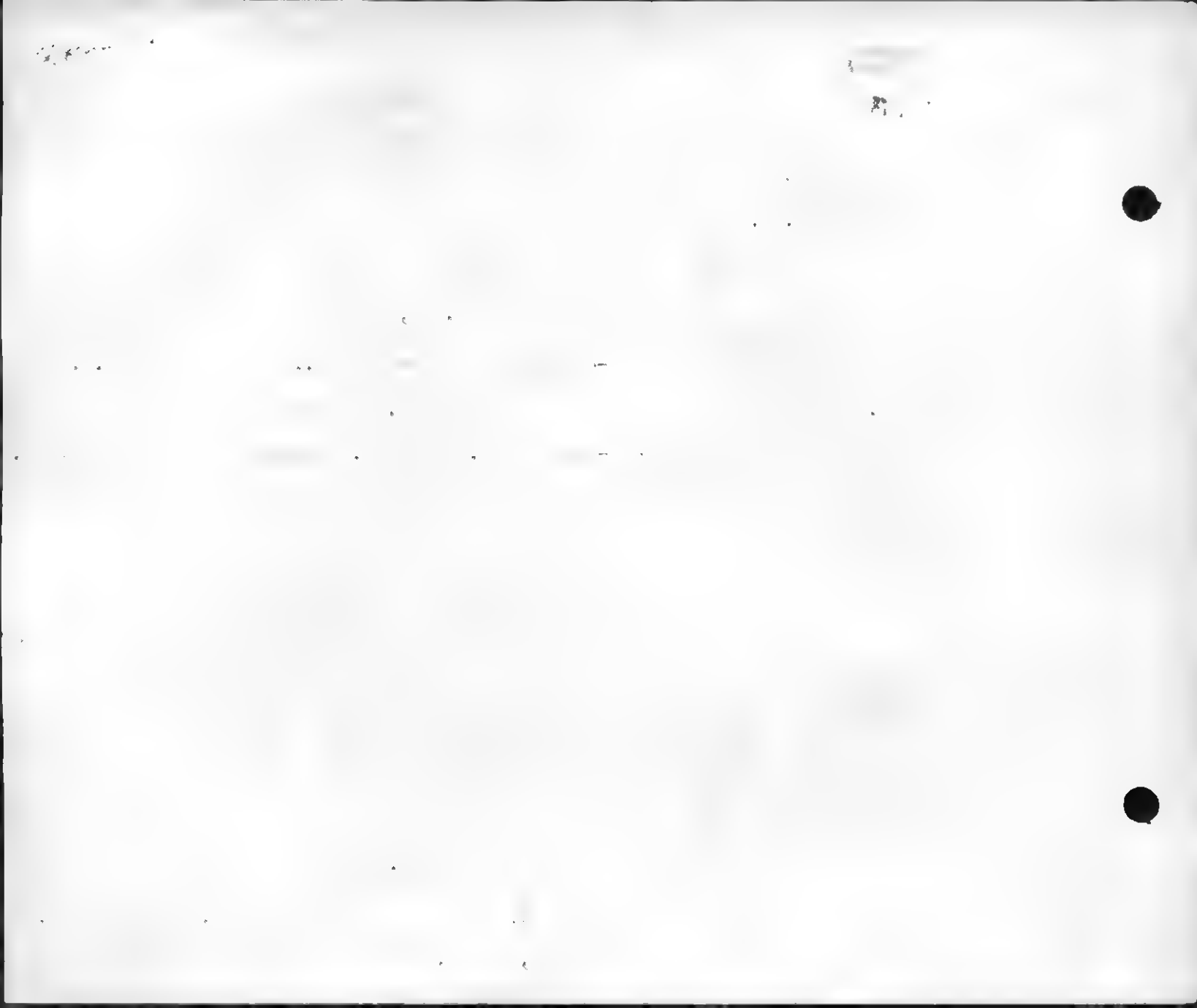
07327

CERTIFICATE OF DEATH

08764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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| | | | | | | | |
|--|---------------------------------|--|---|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY Washington | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown | | | | c LENGTH OF STAY in it 14 yrs | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown R. D. 5 | | | | d STREET ADDRESS Rural Hagerstown | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Wilbur Kelso Kauffman | | | | 4 DATE OF DEATH Month Day Year May 30 1967 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Sept. 15, 1887 | 9. AGE (In years last birthday) 79 yrs | F UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Contractor | | | 10b. KIND OF BUSINESS OR INDUSTRY Self-employed | | 11. BIRTHPLACE (County & State or foreign country) Crawford Co., Ohio | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John L. Kauffman | | | | 14. MOTHER'S MAIDEN NAME Ida M. Bonebrake | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 171-28-6401A | | 17. INFORMANT Address Mrs. Wilbur K. Kauffman Hagerstown #5, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Carcinoma (Site of origin undetermined) 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospitol) attended the deceased from April , 1967, to May 30 , 1967, that (I) (we) last saw the deceased alive on May 29 1967, and that death occurred at 24 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles Spencer | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b DATE SIGNED May 31, 67 | |
| 22c PHYSICIAN'S NAME (Type) Dr. Charles Spencer | | | | 22d ADDRESS 145 S. Prospect St. Hagerstown, Md | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6/1/1967 | | 23c NAME OF CEMETERY OR CREMATORY Green Hill | | 23d LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa. | |
| 24. FUNERAL DIRECTOR Walter J. Gure | | | | 25a. REC'D BY REGISTRAR Waynesboro, Penna. | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |
| | | | | DATE JUN 12 1967 | | | |



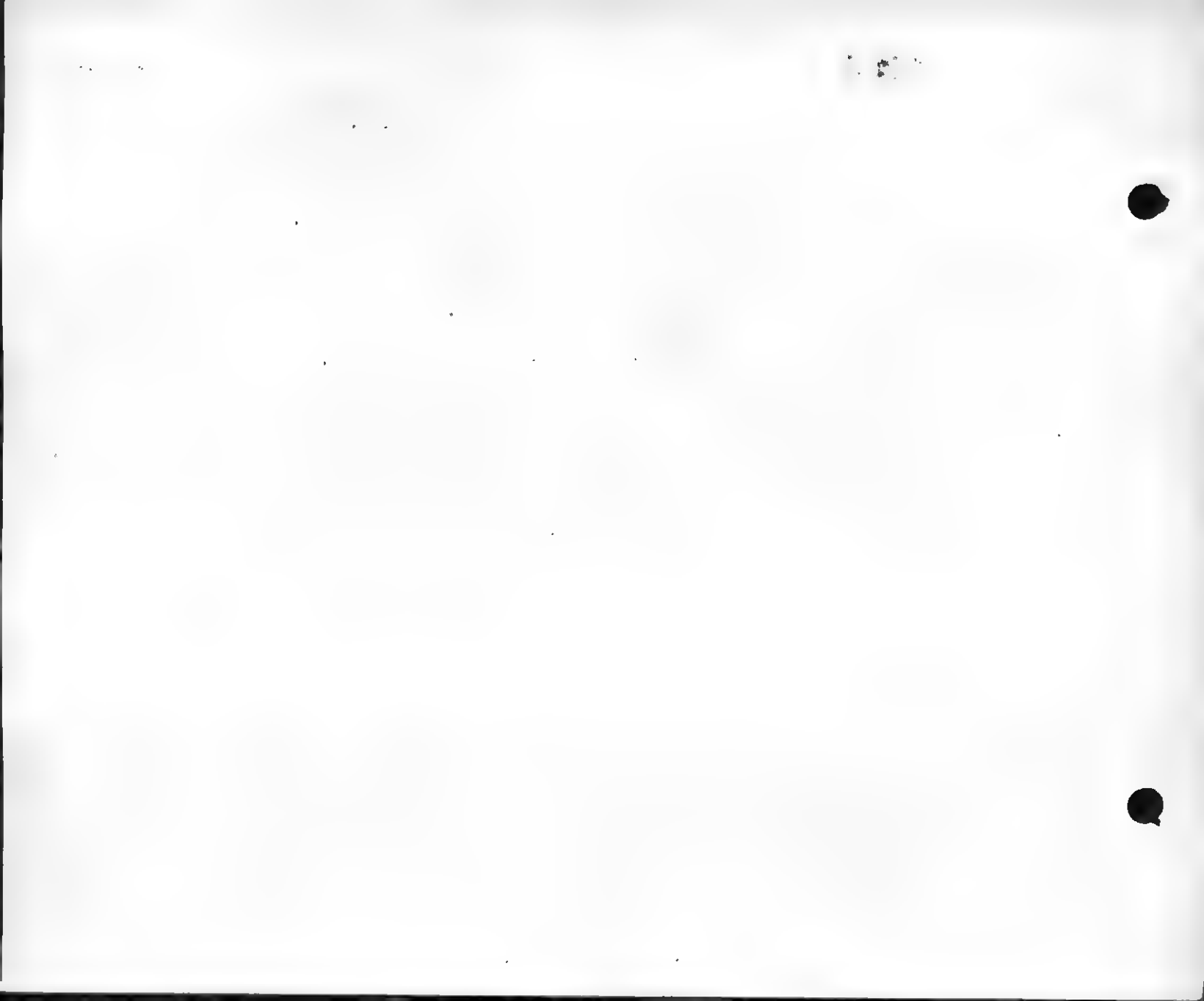
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CERTIFICATE OF DEATH

07305

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. | | b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 10 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | | d. STREET ADDRESS 1 Cheryl Dr. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| NAME OF DECEASED (Type or print) Alma | | First Alma | | Middle Lee | | Last Ketterman | |
| SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 9, 1914 | |
| 9. AGE (In years last birthday) 53 yrs | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS Hours Min | | 4. DATE OF DEATH Month Day Year May 27, 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher | | 10b. KIND OF BUSINESS OR INDUSTRY public school | | 11. BIRTHPLACE (County & State, or foreign country) Hinton, Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Harry Kiser | | | | 14. MOTHER'S MAIDEN NAME Shirley Trumbo | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 531-26-8356 | | 17. INFORMANT Address Josiah Ketterman, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Ovary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-6-66 , 19 66 , to 5-27 , 19 67 ; that (I) (we) last saw the deceased alive on 5/27 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE J.R. Dwyer MD | | 22b. DATE SIGNED 5/27/67 | | | | 22c. PHYSICIAN'S NAME (Type) J.R. Dwyer | |
| 22d. ADDRESS 119 King St Hagerstown Md | | 22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-29-67 | | 23c. NAME OF CEMETERY OR CREMATORY Brandywine Cemetery | | 23d. LOCATION (City or Town) (County) (State) Brandywine, W. Va. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



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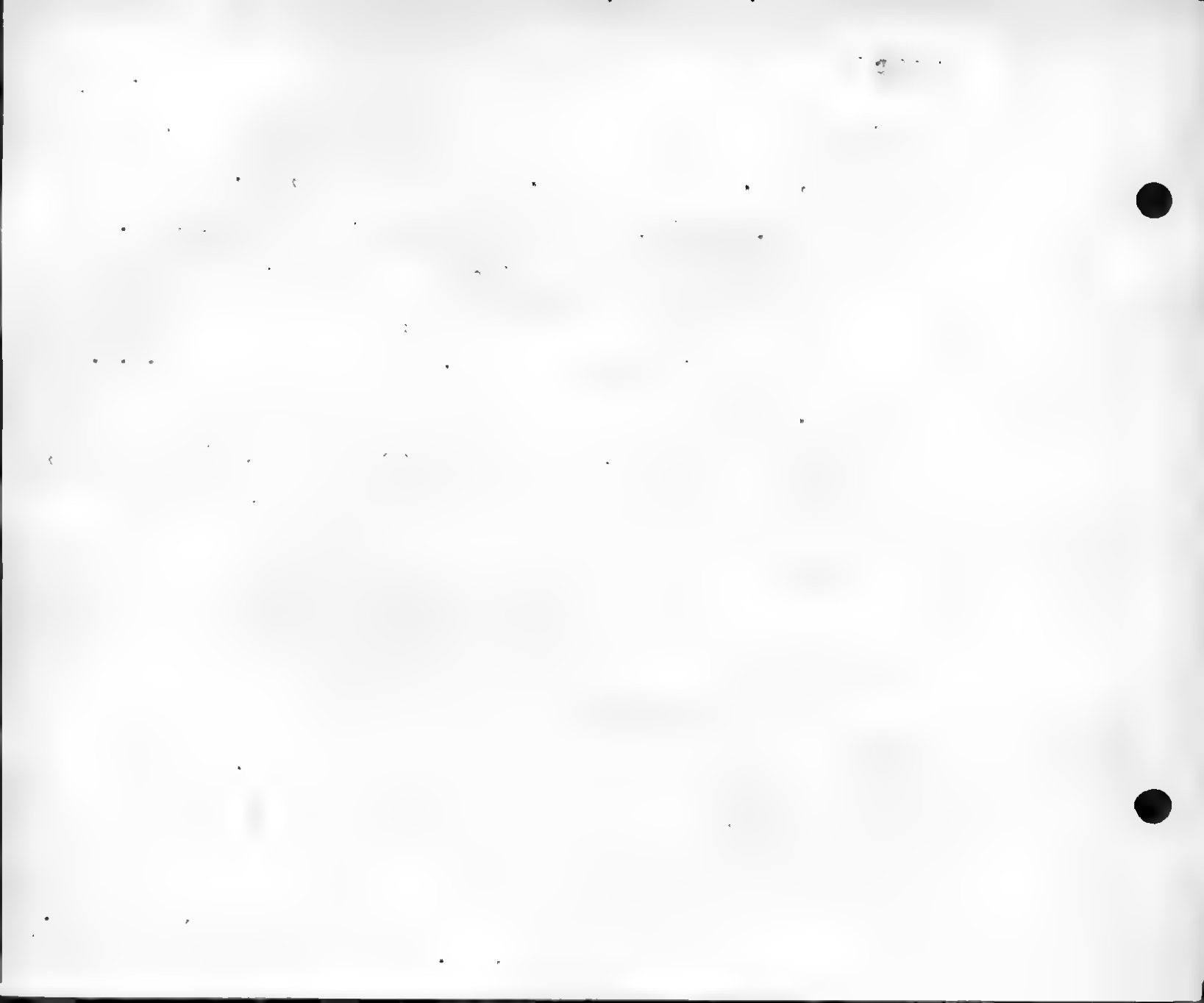
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #16 Film #G348 5/13/67 DC

07329

CERTIFICATE OF DEATH

07306

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Washington | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. | | c LENGTH OF STAY IN 1b 30 hrs. | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital | | d. STREET ADDRESS Rural Clear Spring, Md. | |
| 3 NAME OF DECEASED (Type or print) Roy Franklin Kline | | 4. DATE OF DEATH Month May Day 7 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 26, 1912 |
| 9 AGE (in years lost birthday) yrs 54 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (County & State, or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William E. Kline | | 14. MOTHER'S MAIDEN NAME Mellissa Naille | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 210-77-1528 | |
| 17. INFORMANT Mrs Catharine Kline, Clear Spring, Md | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident DUE TO (b) Emboli DUE TO (c) Thrombotic formation on Aortic arch CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Rheumatic Heart Disease | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from Nov. 1963 to 2/1/1967 , that (I) (we) last saw the deceased alive on 5/7/67 19__, and that death occurred at 7 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE John C. Norton | | 22b. DATE SIGNED 5/8/67 | |
| 22c. PHYSICIAN'S NAME (Type) John C. Norton | | 22d. ADDRESS Hagerstown, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/10/67 | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. |
| 24. FUNERAL DIRECTOR Margaret Rowland | | 25a. REC'D BY REGISTRAR MAY 12 1967 | |
| ADDRESS Clear Spring, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



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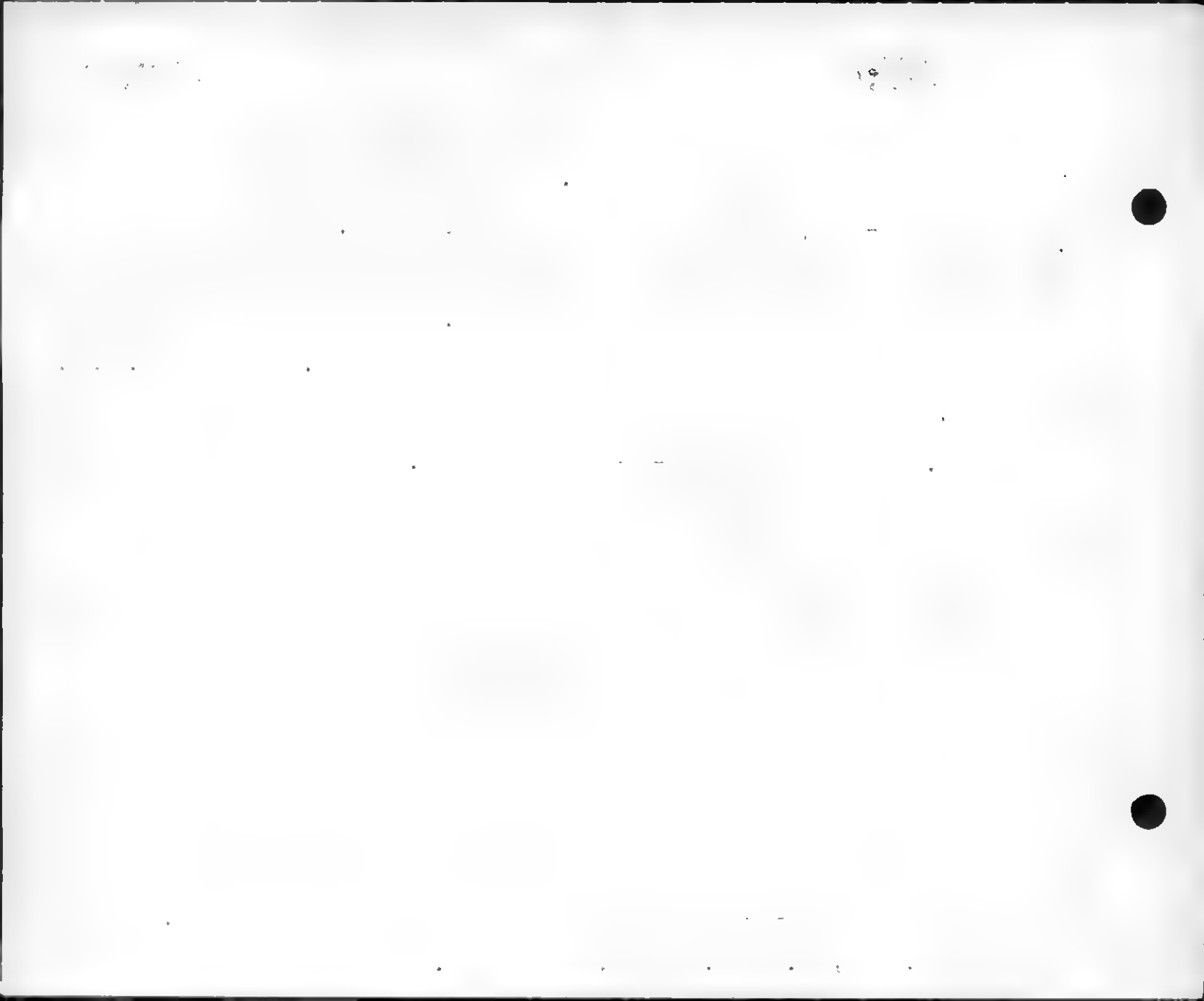
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07330

CERTIFICATE OF DEATH

07307

| | | | | | |
|---|---|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro c. LENGTH OF STAY IN 1b 5 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney- Keedy Memorial Home | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro d. STREET ADDRESS N. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3 NAME OF DECEASED (Type or print) Anna Eugenia Lakin | | | 4 DATE OF DEATH Month May Day 31 Year 19 67 | | |
| 5 SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Sept. 28, 1874 | 9 AGE (in years last birthday) 92 yrs | IF UNDER 1 YEAR Months 8 Days 3 Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (County & State or foreign country) Boonsboro, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME A. William Lakin | | | 14. MOTHER'S MAIDEN NAME Josephine Troup | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO 214-46-5850 | 17. INFORMANT Robert E. Lakin, Boonsboro, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) A. Squamous carcinoma of breast - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7-33- , 19 67 , to 5-31- , 19 67 , that (I) (we) last saw the deceased alive on 5-31- , 19 67 , and that death occurred at 4:30 P M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Joseph H. Bast | | 22b. DATE SIGNED 6-1-67 | | 22c. PHYSICIAN'S NAME (Type) JOSEPH H. SECONDARI | |
| 22d. ADDRESS BOONSBORO MD | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 6-3-67 | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | 23d. LOCATION (City or Town) (County) (State) Boonsboro, Md. | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | 25a. REC'D BY REGISTRAR JUN 5 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07331

07308

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pa. b. COUNTY Franklin | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c LENGTH OF STAY IN 1b 1 Year | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Conv. Home | | d STREET ADDRESS 509 W. Main St. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Annie E. Leedy | | 4 DATE OF DEATH Month Day Year May 25 1967 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/16/1884 |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties | | 10b KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) yrs. 82 |
| 11 BIRTHPLACE (County & State, or foreign country) Manheim, Waynesboro #2 Pa. | | 12 C T ZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Rock | | 14. MOTHER'S MAIDEN NAME Emma Baker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 173-03-1665 | |
| 17. INFORMANT Mr. Ned R. Leedy, 509 W. Main St. | | Address Waynesboro Pa. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>malnutrition</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>300 weeks</i> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f ((y or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1966, to May 1967, that (I) (we) last saw the deceased alive on 5/17 1967, and that death occurred at M, from causes and on the date stated above. | | | |
| 22a SIGNATURE <i>Howard N. Weeks</i> | | 22b DATE SIGNED 5/25/67 | |
| 22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. | | 22d ADDRESS 580 Northern Ave. Hagerstown, Md. | |
| 23a B. RIAL CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 5/27/67 | 23c NAME OF CEMETERY OR CREMATORY Green Hill | 23d LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co., Pa. |
| 24. FUNERAL DIRECTOR Waiter Z. Grove | | 25a. REG. BY REGISTRAR 1967 25b REGISTRAR'S SIGNATURE DATE | |

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1900

1
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| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|----------------------------------|-------------------|---|--|--|--|--|--|---|--|
| 07332 | | | | | | 07309 | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>MORGAN</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> | | | | c. LENGTH OF STAY in 1b <u>40 days</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u> | | | | | | d. STREET ADDRESS <u>R.F.D. #2</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>TRACY HERMAN LINTZ</u> | | | First Middle Last | | | 4. DATE OF DEATH <u>May 19, 1967</u> | | | Month Day Year | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-6-90</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>MORGAN Co., W.Va.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>PETER LINTZ</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE DUCKWALL</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>235-16-3990</u> | | 17. INFORMANT <u>Mrs. T. H. LINTZ - Berkeley Springs, W.Va.</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>452X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured iliac artery aneurysm</u> DUE TO (c) <u>+ hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/13/67</u> , 19 <u> </u> , to <u>5/19/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>5/19/67</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Thomas V. Craig</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>5/24/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas V. Craig, M.D.</u> | | | | | | 22d. ADDRESS <u>Hagerstown, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>5-22-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>DUCKWALL</u> | | 23d. LOCATION (city, town or county) (State) <u>BERKELEY SPRINGS, W.Va.</u> | | | |
| 24. FUNERAL DIRECTOR <u>WM. H. HUNTER</u> | | | | | | 25a. REC'D BY REGISTRAR <u>BERKELEY SPRINGS, W.Va.</u> | | 25b. REGISTRAR'S SIGNATURE <u>DATE MAY 24 1967</u> | | | |

Handwritten text in Arabic script, likely a title or heading, possibly reading "كتاب..." (Book of...).

Handwritten text in Arabic script, likely a signature or date, possibly reading "تاريخ..." (Date/History of...).

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

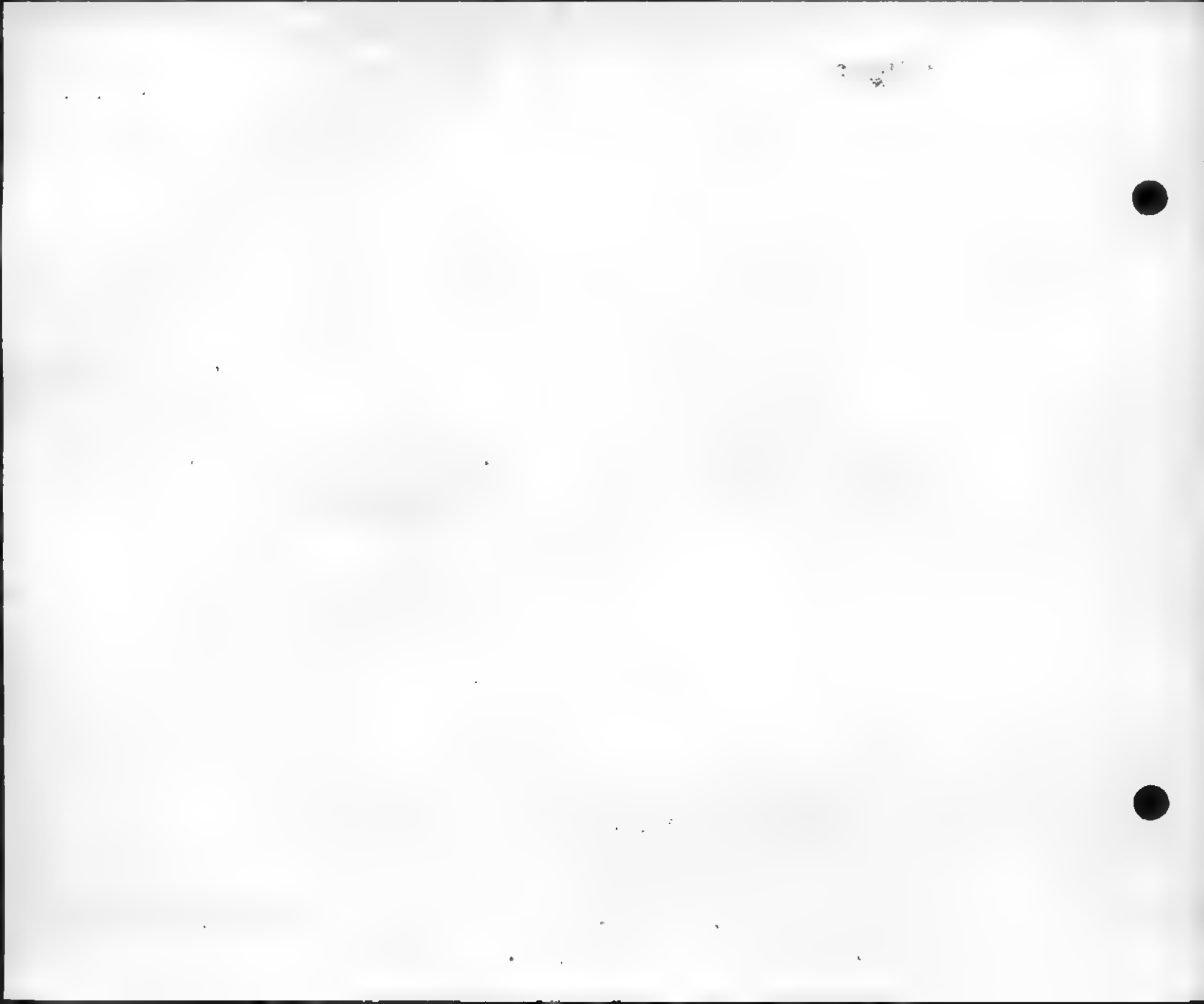
07333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07310

| | | | | | |
|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route 60 | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Rt 5 Leightersburg | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | d. STREET ADDRESS Route 5 | | |
| 3. NAME OF DECEASED (Type or print) First Patrick Middle Owen Last Lloyd | | | 4. DATE OF DEATH Month May Day 24 Year 1967 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1967 | 9. AGE (In years last birthday) 27 yrs | IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Hagerstown, Md. | |
| 13. FATHER'S NAME Richard Lee Lloyd | | | 14. MOTHER'S MAIDEN NAME Yvonne E. Winterstine | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO none | | 17. INFORMANT Address Mr. Frank Winterstine, Rt. 4 Cumberland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain damage from fractured skull 8254 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| 20a. EXTERNAL CAUSE WAS PRIMARY CAUSE CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Auto-auto collision on Rt. 60, Wash. Co., Md. | | | |
| 20c. TIME OF INJURY Month, Day, Year 12:15 pm 5/24 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway | | 20f. (City or town) (County) (State) Hagerstown Wash. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 5/25/67 22. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF May 27, 1967 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md. | | | 25a. REC'D BY REGISTRAR MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

7 227387



07334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07311

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c LENGTH OF STAY IN b LIFE | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d STREET ADDRESS 624 WEST FRANKLIN STREET, | |
| 3 NAME OF DECEASED (Type or print) First Middle Last ERNEST FRANKLIN MARTIN | | 4 DATE OF DEATH Month Day Year MAY 14, 19 67 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH SEPT. 2, 1914 |
| 9 AGE (In years last birthday) 52 yrs. | | 10 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USLA OCCUPATION (Give kind of work done during most of work no life, even if retired) CHANGE CONTROLLER | | 10b KIND OF BUSINESS OR IND. STRY FAIRCHILD-HILLER | |
| 11 BIRTHPLACE (State or foreign country) WASHINGTON CO. MARYLAND. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME HARRY E. MARTIN | | 14 MOTHER'S MAIDEN NAME CARRIE FOUKE | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) NO ***** | | 16 SOCIAL SECURITY NO 214-09-6495 | |
| 17 INFORMANT MRS. REBA C. MARTIN, | | 624 West FRANKLIN ST. HAGERSTOWN, MARYLAND. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO (b) Arterio-sclerosis, generalized and (c) Arterio-sclerotic heart & Disease INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward W. Ditto M.D. | | 22. DATE SIGNED 5/16/67 | |
| EXAMINER'S NAME (Type) DR. EDWARD W. DITTO, III M.D. | | Address (Street city town or county) Hagerstown, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5/18/67 | 23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY, | 23d LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | 25a REC'D BY REGISTRAR MAY 19 1967 DATE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove these papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

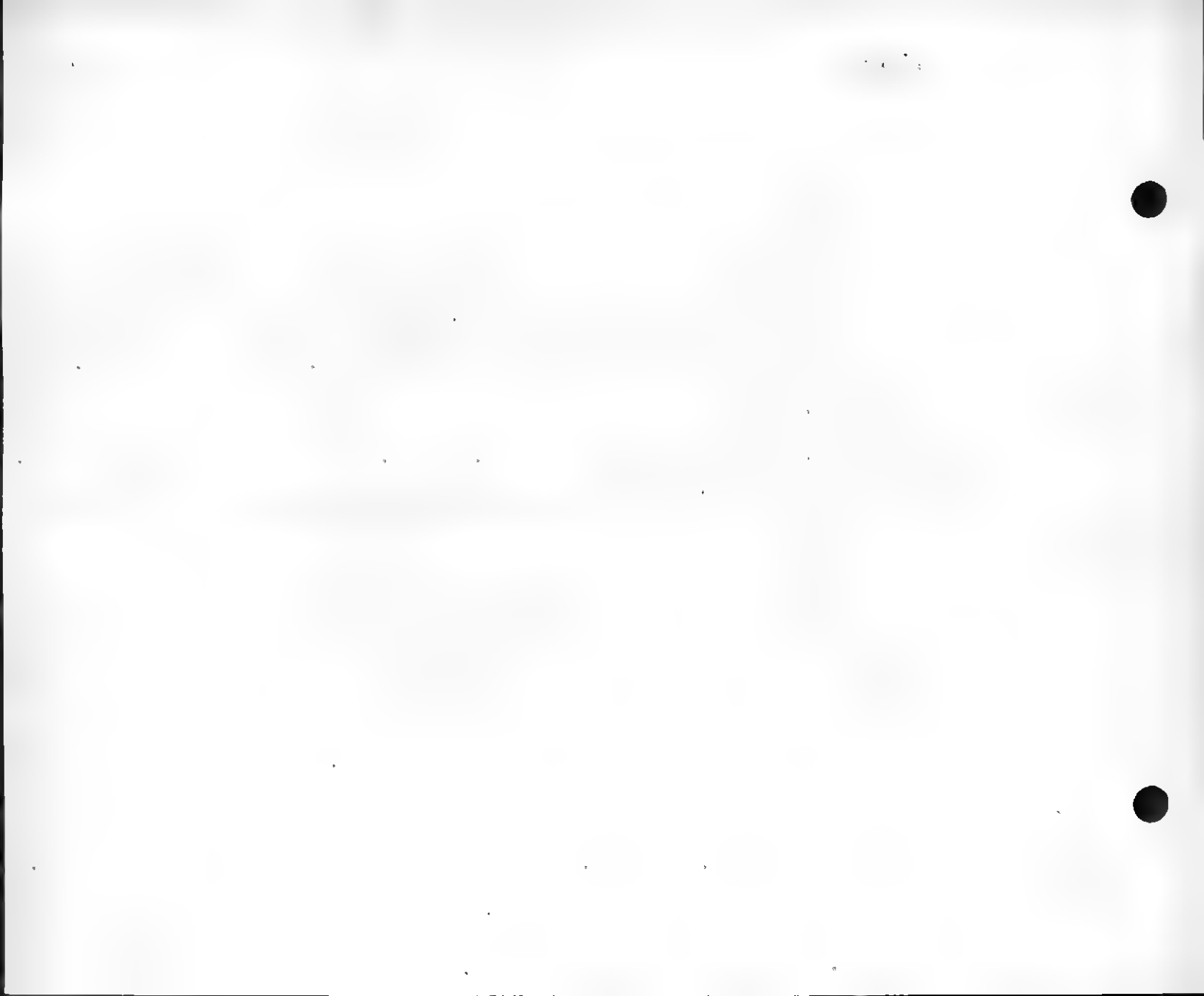
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07335

CERTIFICATE OF DEATH

07312

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN IB LIFE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 957 VIEW STREET, | | d. STREET ADDRESS 957 VIEW STREET, | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LEWIS AUGUSTIN MARTIN | | 4. DATE OF DEATH Month Day Year MAY 4, 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 29, 1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MANAGER | | 10b. KIND OF BUSINESS OR INDUSTRY PEOPLES DRUG STORE | 9. AGE (In years lost birthday) 71 yrs |
| 11. BIRTHPLACE (County & State or foreign country) WASHINGTON CO. MARYLAND. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN D. MARTIN | | 14. MOTHER'S MAIDEN NAME HENRIETTA HANN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES W.W. # 1 | | 16. SOCIAL SECURITY NO 214-09-0207 A | |
| 17. INFORMANT MRS. MYRA C. MARTIN, | | Address 957 VIEW STREET, HAGERSTOWN, MARYLAND. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (X) DECEASED attended the deceased from 11-26, 19 47, to 5-4, 19 67, that (I) was lost saw the deceased alive on 5-4-1967, and that death occurred at 1 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dalton M. Welty</u> | | 22b. DATE SIGNED MAY 6, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) DR. DALTON M. WELTY, M.D. | | 22d. ADDRESS 998 POTOMAC AVE. HAGERSTOWN, MARYLAND. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5/8/67 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | 25a. REC'D BY REGISTRAR MAY 9 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

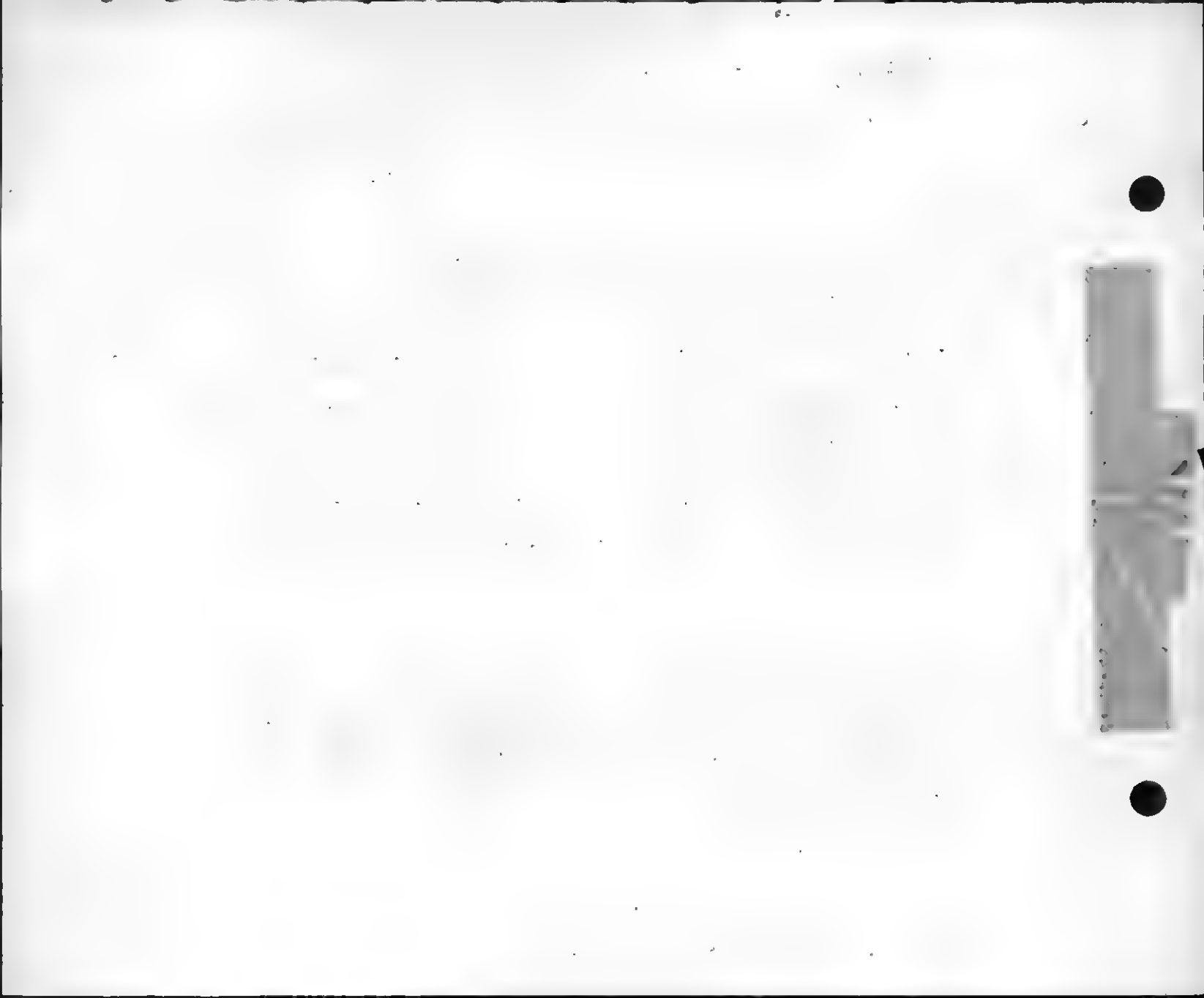


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN ID <u>2 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown RFD #4</u> d. STREET ADDRESS <u>RFD# 4</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Leshner</u> Last <u>Martin</u> | | | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 4 1888</u> | | 9. AGE (in years last birthday) <u>78 yrs.</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>25</u> Hours <u></u> Min. <u></u> | | 10. BIRTHPLACE (County & State, or foreign country) <u>State line Pa.</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Farmer</u> | | | | | | 12. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | | | | |
| 13. FATHER'S NAME <u>David H Martin</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Eshelman</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>217 10 2691</u> | | | | | |
| 17. INFORMANT <u>Mrs. Helen Shank Martin</u> Address <u>Hagerstown Md..</u> | | | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 yrs</u> | | | | | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21. MEDICAL CERTIFICATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>6/30</u> 21d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6/30</u> 21f. (City or town) (County) (State) <u>6/30</u> <u>MD</u> <u>5/30</u> <u>1967</u> | | | | | | 22. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> , 19 <u>67</u> , to <u>5/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>67</u> , and that death occurred at <u>3:40</u> M., from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Donald E. Martin</u> | | | | | | 22b. DATE SIGNED <u>5/31/67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u> | | | | | | 22d. ADDRESS <u>418 N. Potomac St., Hagerstown, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>June 2-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor Lutheran Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Fairview Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR <u>DATE JUN 2 1967</u> | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | |

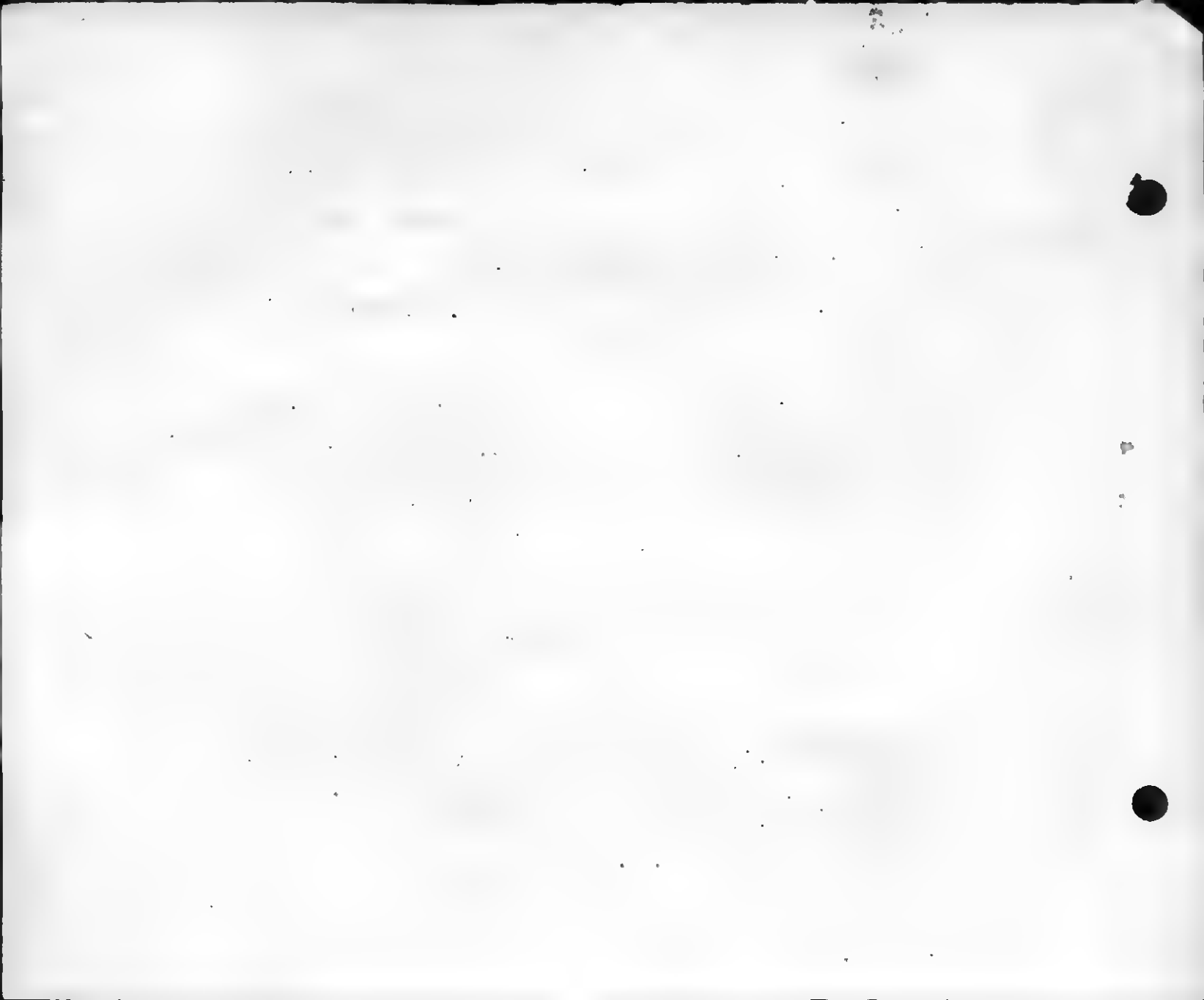


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07337 CERTIFICATE OF DEATH 07314

| | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 10 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | | e. STREET ADDRESS Falling Waters Road | | | |
| 3. NAME OF DECEASED (Type or print) First VIRGINIA Middle NANCY Last MAUCK | | | | 4. DATE OF DEATH Month May Day 25 Year 19 67 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 28, 1910 | |
| | | | | 9. AGE (In years last birthday) 56 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 26 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | |
| 13. FATHER'S NAME Peter Ruffner | | | | 14. MOTHER'S MAIDEN NAME Rebecca Sweitzer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Mr.. Russell R. Mauck | |
| | | | | Address Williamsport Maryland RFD #1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carotid aneurysm DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pancreatic hemorrhage | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1201 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this physician) attended the deceased from June 2, 19 59, to May 25, 19 67, that (I) (we) last saw the deceased alive on May 24, 19 67, and that death occurred at 12:00 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE M. E. Byrkit | | | | 22b. DATE SIGNED May 26, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) M. E. Byrkit, M. D. | | | | 22d. ADDRESS 28 West Potomac Street Williamsport, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF May 28 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | |
| | | | | 23d. LOCATION (City, town or county) (State) Williamsport Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS Albert L.. Leaf Williamsport Md. | | | | 25a. REC'D BY REGISTRAR MAY 31 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



1
FOR STATE
HEALTH DEPT.

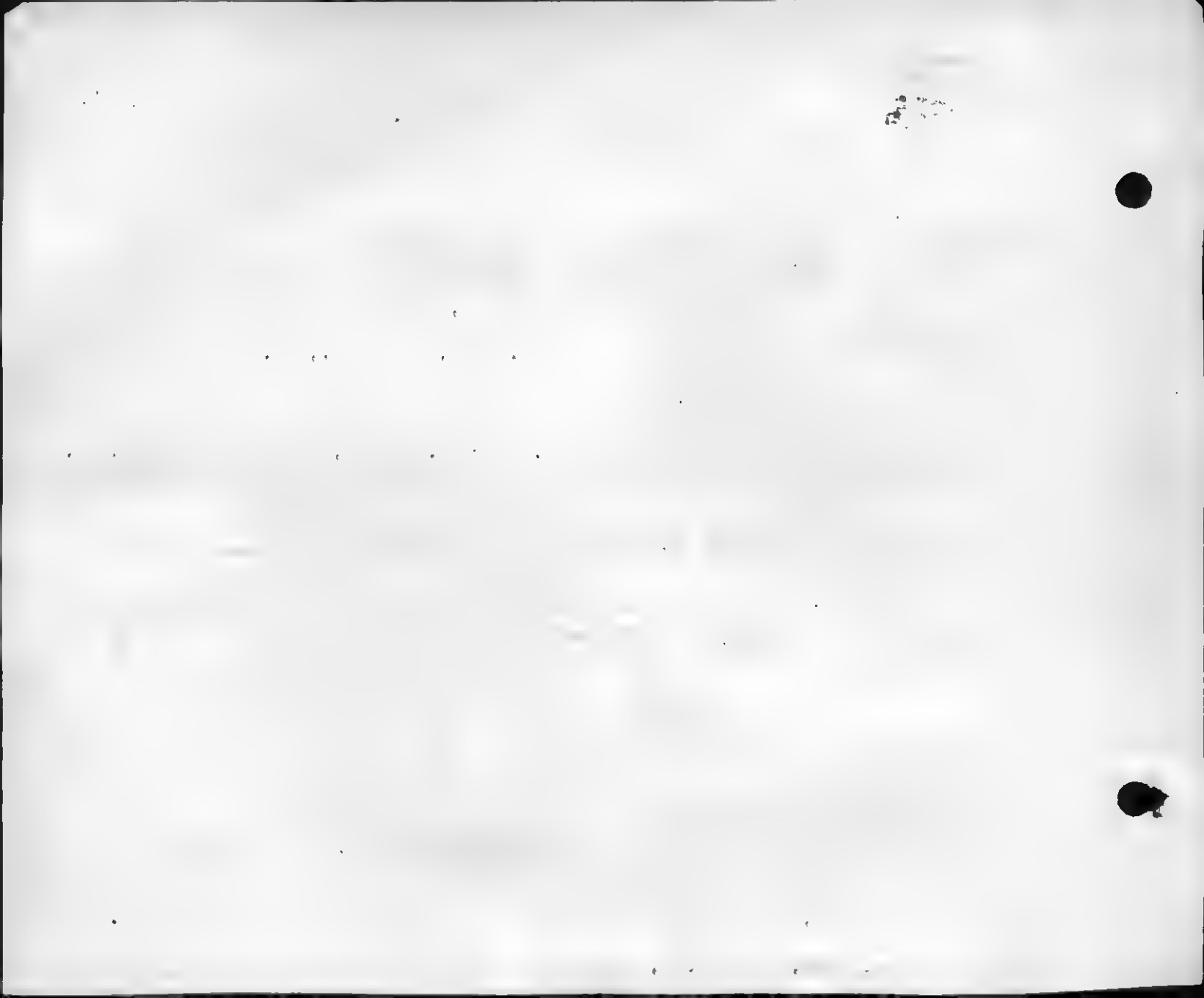
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07338

07615

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. | | b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN b 9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS RFD #1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Newton Snively McCarney | | 4. DATE OF DEATH Month May Day 12 Year 1967 | | 5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House Painter | | 9. BIRTHPLACE (State or foreign country) Mt. Hope, Adams Co., Pa. | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 11. FATHER'S NAME Levi Baldwin McCarney | | 12. MOTHER'S MAIDEN NAME Sarah Ann Watson | | 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no | |
| 14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli, Bilateral (b) Phlebotrombosis, Left + lower Extremity (c) Aspiration of Gastric Fluid | | 15. SOCIAL SECURITY NO. 173-03-3534A | | 16. INFORMANT Mrs. Alice M. Thomas, Blue Ridge Summit, Pa. | |
| 17. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 18. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. TIME OF INJURY Month 19 Day 19 Year 1967 | | 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smithsburg, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22a. ACTUAL SIGNATURE Edward W. Dittus III | | 22b. DATE SIGNED 5/16/67 | |
| 22c. EXAMINER'S NAME Edward W. Dittus III | | 22d. LOCATION (City, town, or country) Smithsburg, Md. | | 22e. REGISTRAR'S SIGNATURE Charles Judge | |
| 23. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Maryland | | 23a. ADDRESS Smithsburg, Md. | | 23b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

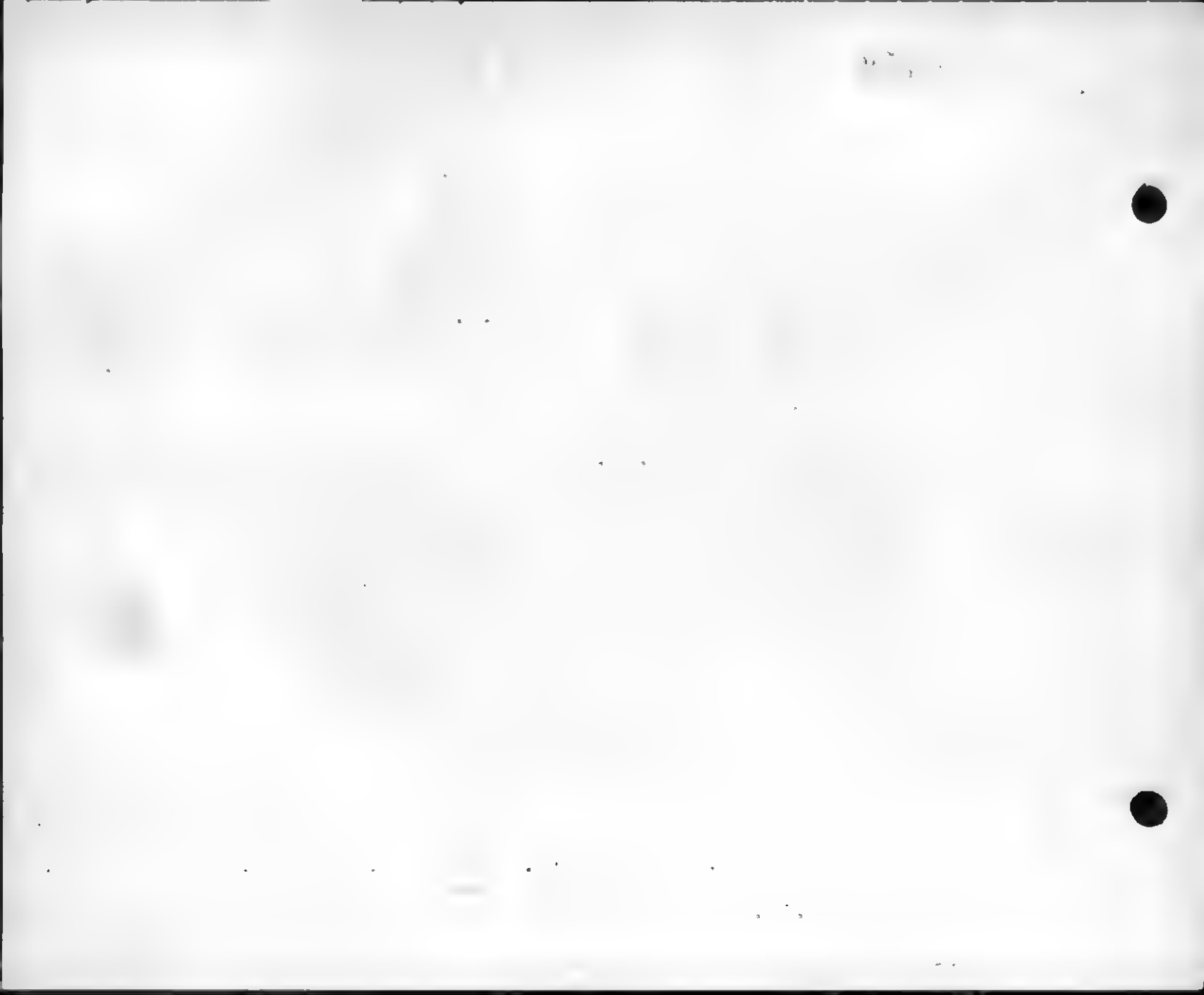
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07339

CERTIFICATE OF DEATH

07316

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d STREET ADDRESS | |
| HOME | | HANCOCK MARYLAND | |
| 3 NAME OF DECEASED (Type or print) First Middle Last JOHN HERMAS MCGOWAN | | 4 DATE OF DEATH Month Day Year 5 14 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8.1.1920 |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) MORGAN COUNTY W.VA. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN W MCGOWAN | | 14. MOTHER'S MAIDEN NAME MINNIE M EVERSOLE | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 11 | | 16 SOCIAL SECURITY NO 235.16.8108 | |
| 17 INFORMANT LLOYD G MCGOWAN | | Address 212 TERRACE HANCOCK MD. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | INTERVA. BETWEEN ONSET AND DEATH unknown seen at least 24 hrs after death | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heavy smoker & drinker | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF LATER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 1-9-67, to 4-27-1967 that (1) (we) last saw the deceased alive on 4-27-1967, and that death occurred on M, from causes and on the date stated above. | | | |
| 22a SIGNATURE Charles R. Wierer M.D. | | 22b DATE SIGNED 5-16-67 | |
| 22c PHYSICIAN'S NAME (Type) Charles R. Wierer, M.D. | | 22d ADDRESS 238 E. Main St., Hancock, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF 5.13.67 | 23c NAME OF CEMETERY OR BURIAL PLACE GREAT HARBOR CAPON | 23d LOCATION (City or town) (County) (State) GREAT CAPON MORGAN W.VA. |
| 24 FUNERAL DIRECTOR Harold F. Elmore Hancock, Md. | | 25a REC'D BY REGISTRAR MAY 19 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07340

CERTIFICATE OF DEATH

07317

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Penna. b. COUNTY Fulton ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McConnellsburg | |
| c. LENGTH OF STAY IN b. 5 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS Lincoln Way, E. | |
| 3. NAME OF DECEASED (Type or print) CLAUDE LIONEL MELLOTT | | 4. DATE OF DEATH Month May , Day 10 , Year 1967 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 2, 1903 |
| 9. AGE (in years last birthday) 64 yrs | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Webster Mills, Pa. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Gilbert B. Mellott | | 14. MOTHER'S MAIDEN NAME Leticia Whitfield | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Elena V. Mellott, McConnellsburg, Pa | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction with arrhythmia 4/20/1 DUE TO (b) coronary artery disease DUE TO (c) generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH minutes years years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) prostatic hypertrophy | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from , 19 , to 11 May, 1967 , that (I) (we) last saw the deceased alive on 10 May 1967 , and that death occurred at M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John C. Stauffer | | 22b. DATE SIGNED 5-11-67 | |
| 22c. PHYSICIAN'S NAME (Type) John C. Stauffer | | 22d. ADDRESS 145 S. Prospect St. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-14-67 | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | 23d. LOCATION (City or Town) (County) (State) McConnellsburg, Pa. |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REG'D BY REGISTRAR DATE MAY 15 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000 1000 1000

07318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN lb <u>2 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u> | | d. STREET ADDRESS <u>417 Brewster Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>H.</u> Last <u>Milburn</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>February 24, 1872</u> | |
| 9. AGE (In years last birthday) <u>95</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u> | | 12. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 13. FATHER'S NAME <u>James Milburn</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Catherine Grove</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Agnes Suncie, Hagerstown, Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 42° 0' DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic heart disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized arteriosclerosis</u> | |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 22. B. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 23. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>min.</u> <u>p.m.</u> <u> </u> <u> </u> <u>19</u> | | 24. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> | |
| 25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 26. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> | |
| 27. I certify that (I) (this hospital) attended the deceased from <u>1-9-64</u> to <u>3-27-1967</u> that (I) (we) last saw the deceased alive on <u>3-27-1967</u> and that death occurred <u>3:27 P.M.</u> from the causes and on the date stated above | | 28. SIGNATURE <u>Robert F. Keadle</u> M.D. | |
| 29. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u> | | 30. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-29-67</u> | |
| 31. ADDRESS <u>580 Northern Ave., Hagerstown, Md 21740</u> | | 32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 33. DATE THEREOF <u>5/30/1967</u> | | 34. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u> | |
| 35. LOCATION (City, town or county) (State) <u>Washington Co Maryland</u> | | 36. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman, Green with, Pa</u> | |
| 37. ADDRESS <u> </u> | | 38. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u> | |
| 39. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 40. REGISTRAR'S SIGNATURE <u> </u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

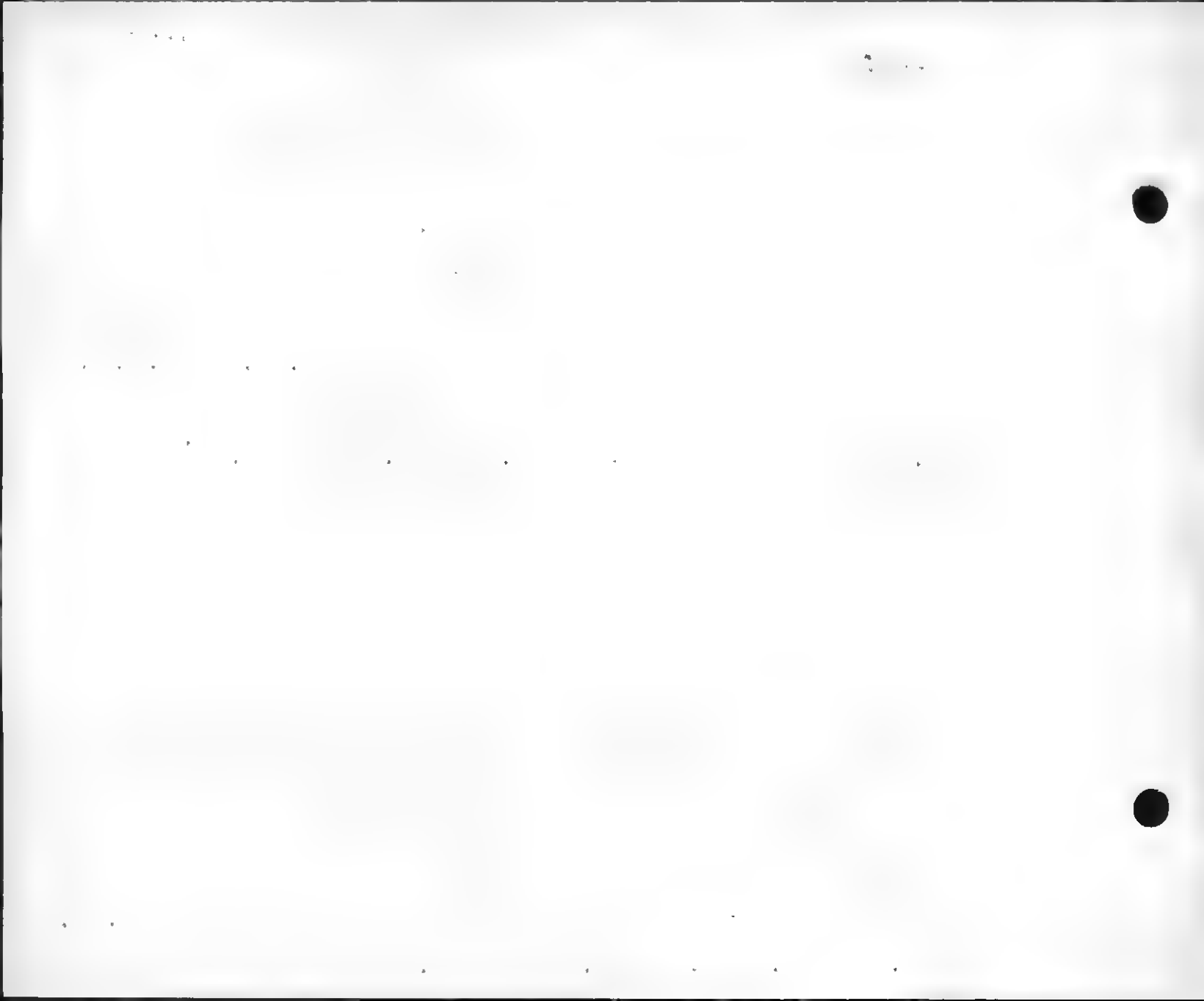
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07342

CERTIFICATE OF DEATH

07319

| | | | | | |
|---|--|---|--|---|----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown d. STREET ADDRESS Rfd. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3 NAME OF DECEASED (Type or print) Julia Ann Miller First Middle Last 4. DATE OF DEATH May 20, 1967 Month Day Year | | | 5 SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 10, 1907 9. AGE (In years last birthday) 59 10. IF UNDER 1 YEAR Months Days Hours Min 11 10 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Frank Leonard | | 14. MOTHER'S MAIDEN NAME Harriet Ellen Barthlow | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 187-16-6108 | | 17. INFORMANT Mr. George E. Miller, Rfd. 3 Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of bladder & rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 39 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro, Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from May 16, 1967 to May 20, 1967 , that (I) (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 11A M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE G. W. Levan | | 22b. PHYSICIAN'S NAME (Type) G. W. Levan | | 22c. ADDRESS Boonsboro, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-23-67 | | 23c. NAME OF CEMETERY OR CREMATORY Tuscarora Cemetery | |
| 23d. LOCATION (City or Town) Rural Martinsburg, W. Va. | | 23e. REC'D BY REGISTRAR MAI 25 1967 | | 23f. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | |



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

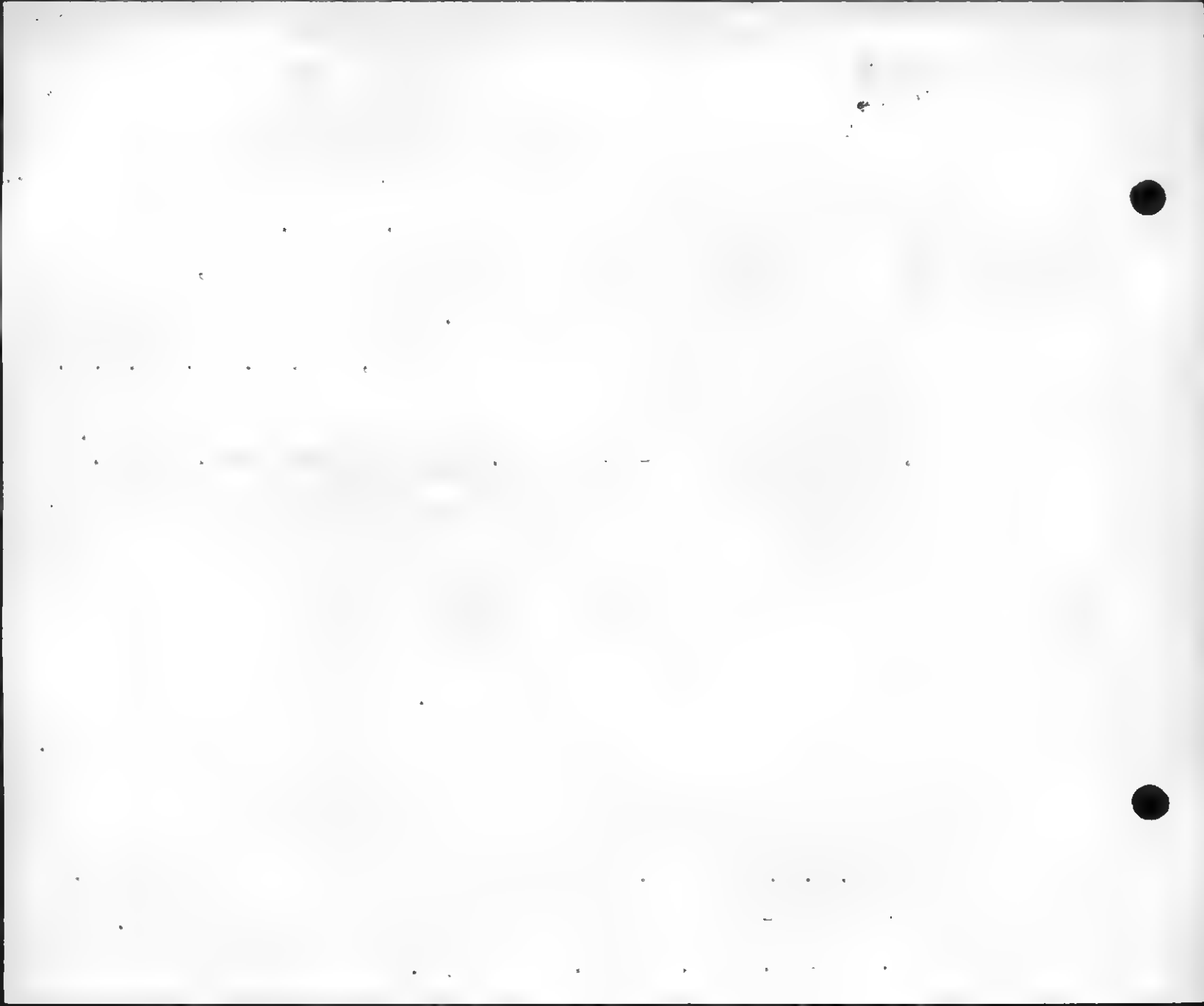
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07320

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 2 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | d. STREET ADDRESS 307 N. Main St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ruby Mae Miller | | | 4. DATE OF DEATH Month Day Year May 4, 19 67 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 6, 1926 | 9. AGE (In years last birthday) 40 yrs. | IF UNDER 1 YEAR Months Days Hours Min 7 28 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Benevola, Wash. Co., Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Charles Turner | | |
| 14. MOTHER'S MAIDEN NAME Lovetta Poffenberger | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | |
| 16. SOCIAL SECURITY NO. 218-30-9809 | | | 17. INFORMANT Boonsboro, Md. Mr. Gerald L. Miller, 307 N. Main St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 771.8 POISONING (drank kerosene) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient drank kerosene. | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Patient drank kerosene. | | | |
| 20c. TIME OF INJURY Month, Day, Year 2 Hour May 2, 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | |
| 20f. (City or town) Boonsboro, Washington, Md. | | 20g. (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | M.D. | | 22. DATE SIGNED May 6, 1967 | |
| EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | Address (Street, city, town, or county) Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-7-67 | | 23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery | |
| 23d. LOCATION (City or Town) Rohreraville, Md. | | 23e. (County) (State) | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR MAY 9 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

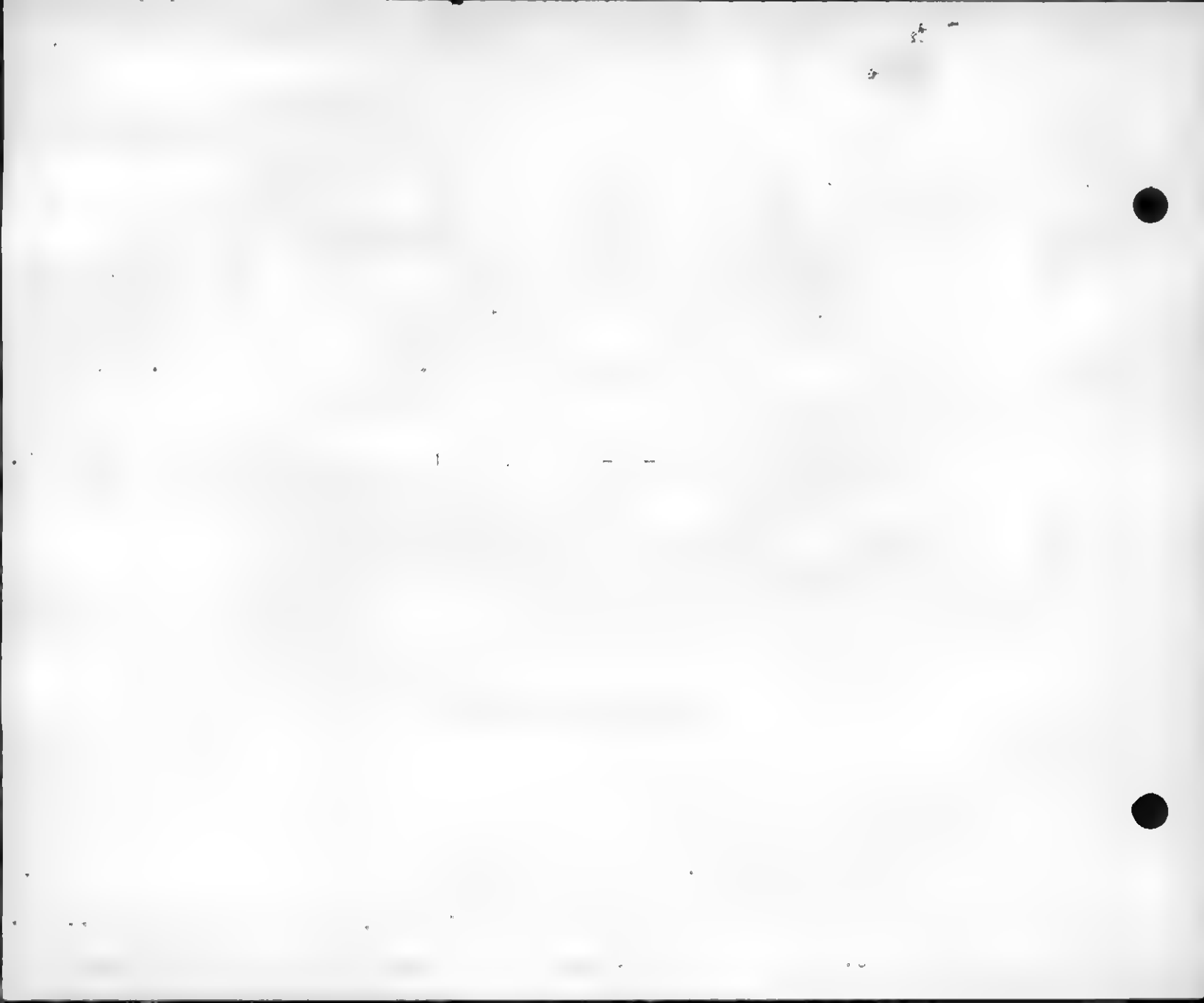
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07344

CERTIFICATE OF DEATH

07321

| | | | | | | | |
|---|---------------------------------|---|---------------------------------------|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK | | | | c. LENGTH OF STAY IN 1b LIFE | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK | | | | d. STREET ADDRESS RURAL 2, HANCOCK | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last HILLARD WILSON MILLS | | | | 4 DATE OF DEATH Month Day Year MAY 21, 1967 | | | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/25/1910 | 9. AGE (in years last birthday) 56 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 11 BIRTHPLACE (County & State, or foreign country) WASH. CO., MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL MILLS | | | | 14. MOTHER'S MAIDEN NAME CELIA HULL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 220-09-9261 | | 17. INFORMANT Address VIRGINIA SHOEMAKER RFD 2, HANCOCK MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Advanced Emphysema & Asthmatic Bronchitis (b) Pulmonary Hemorrhage | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) intermittent heavy alcohol intake | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 23, 1966 to June 16, 1966 that (I) (we) last saw the deceased alive on June 16, 1966 , and that death occurred at 2:45 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles R. Wierer | | | | 22b. DATE SIGNED May 25, 1967 | | 22c. PHYSICIAN'S NAME (Type) Charles R. Wierer, M.D. | |
| 22d. ADDRESS 238 Main St., Hancock, Md. | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. ATTENDING PHYS. <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 5/25/67 | | 23c. NAME OF CEMETERY OR CREMATORIUM ORCHARD RIDGE 1ST CH. | | 23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK WASH., MD. | |
| 24. FUNERAL DIRECTOR RICHARD J. GROVE HANCOCK, MARYLAND | | | | 25a. REC'D BY REGISTRAR MAY 26 1967 | | 25b. REGISTRAR'S SIGNATURE Charles George | |

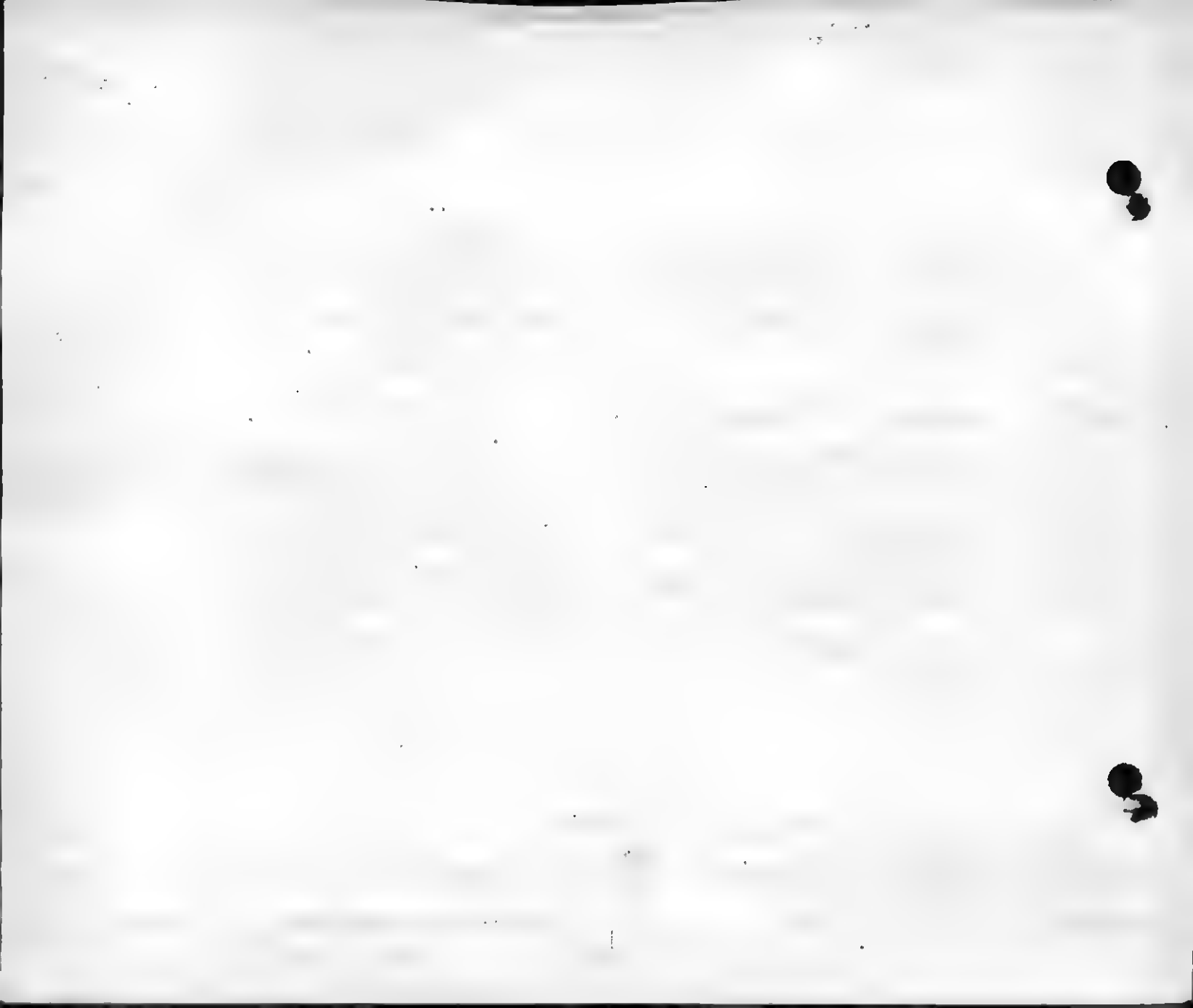


1
FOR STATE
HEALTH DEPT.

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VR AISME
SM 1/63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--------------------------------------|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 07345 | | | | | | 07322 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville | | | | | | c. LENGTH OF STAY IN 1b 6 yrs | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 N. Main Street | | | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville | | | | | |
| f. STREET ADDRESS 5 N.. Main Street | | | | | | g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Charles Earl Moats | | | | | | 4. DATE OF DEATH May 5 19 67 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 10 1929 | | 9. AGE (In years last birthday) 37 yrs. | | IF UNDER 1 YEAR Months 11 Days 25 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Air Craft | | 11. BIRTHPLACE (State or foreign country) Williamsport Md. | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A | | | |
| 13. FATHER'S NAME Willard Moats | | | | | | 14. MOTHER'S MAIDEN NAME Pauline Cottrill | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 212 26 4406 | | 17. INFORMANT Mrs.. Vivian Arlene Moats | | 5 N Main St address Keedysville Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Spontaneous Aneurysm Rupture of Lt. Coronary Artery | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10-15m | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Artery | | | | | | | | | | | |
| (c) Severe Coronary atherosclerosis | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto 3rd. | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) Edward W. Ditto 3rd. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | DATE SIGNED 5-6-67 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 22b. DATE THEREOF May 8-67 | | 22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery | | 22d. LOCATION (City, town, or county) (State) Bakersville Maryland | |
| 23. FUNERAL DIRECTOR Albert L. Leaf | | | | | | ADDRESS Williamsport Maryland | | 24a. REC'D BY REGISTRAR MAY 9 1967 | | 24b. REGISTRAR'S SIGNATURE J. Charles Judge | |





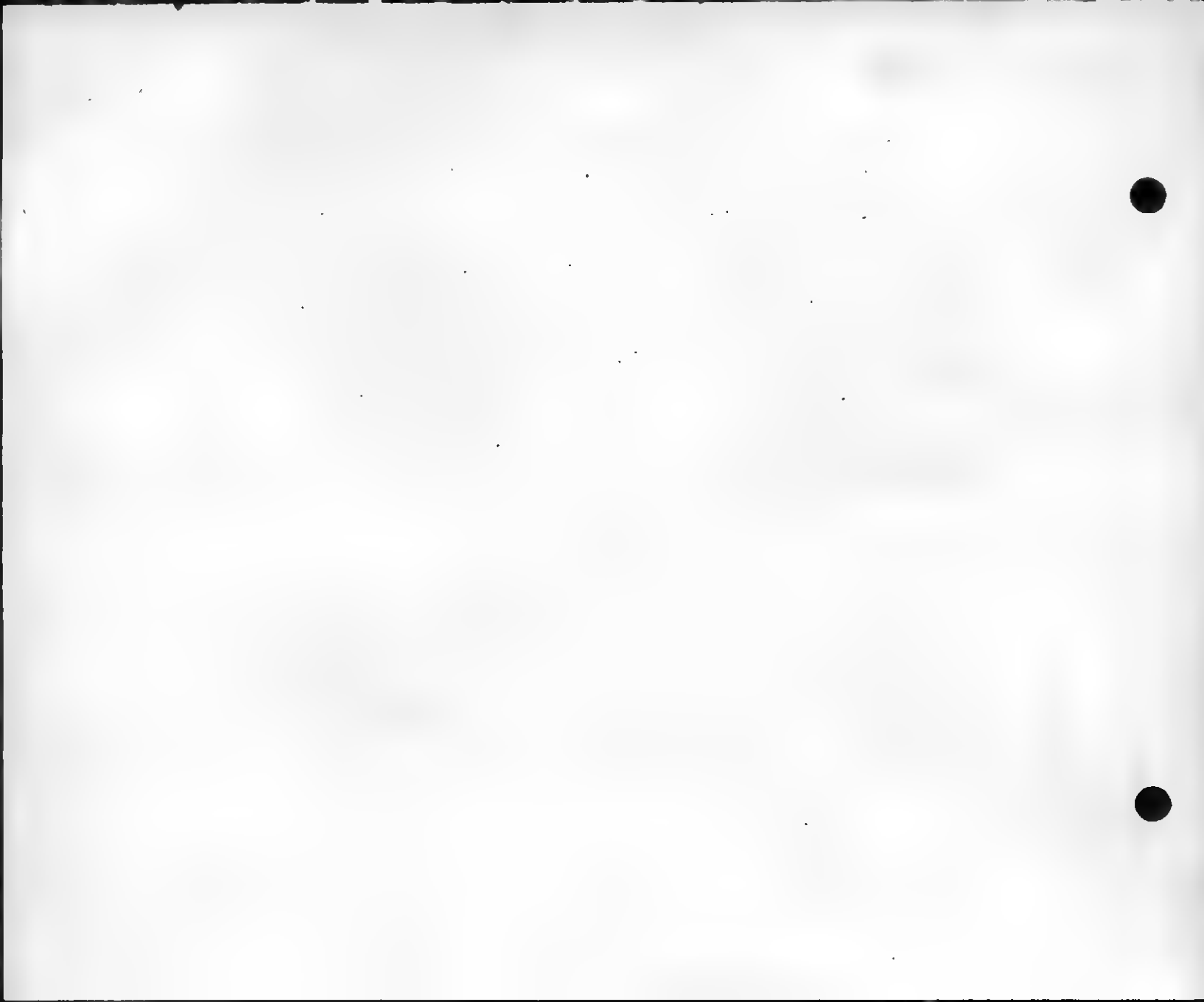
1
FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07323

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 72 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 258 S. Locust St. | | d. STREET ADDRESS 258 S. Locust St. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frances Beatrice Mongan | | 4. DATE OF DEATH Month Day Year May 21 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 8, 1895 |
| 9. AGE (in years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Washington Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Harvey Kridler | | 14. MOTHER'S MAIDEN NAME Ida Chaplin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Faith Olive Vincent, Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Athrosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa lest. | | | INTERVAL BETWEEN ONSET AND DEATH sudden years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE  | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Howard N. Weeks, M.D. | | Address (Street, city, town, or county) 580 Northern Ave. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/23/67 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Mem. Park | 23d. LOCATION (City, town or county) (State) Hagerstown, Md. |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE DATE MAY 26 1967  | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07347

CERTIFICATE OF DEATH

07324

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS 1013 | |
| 3 NAME OF DECEASED (Type or print) John First R. Monroe Middle Last | | 4 DATE OF DEATH Month 5 Day 26 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE Negro | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/17/91 |
| 9 AGE (In years last birthday) yrs 75 | | IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10 | |
| 10a. USUAL OCCUPATION (Give kind of work done during last 12 months) Employed as a custodian | | 10b. KIND OF BUSINESS OR OCCUPATION Custodian | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Unknown | | 14 MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 216-14-4992-A | |
| 17 INFORMANT Mrs. Anna G. Monroe, Knoxville Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Renal upt and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Renal infarct DUE TO (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John J. Donoghue M.D. | | 22b. DATE SIGNED 5-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) John J. Donoghue | | 22d. ADDRESS 300 Northern Ave. Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/29/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | 23d. LOCATION (City or Town) (County) (State) Petersville, Md. |
| 24. FUNERAL DIRECTOR Teete Funeral Home | | 25a. BY D. BY REGISTRAR DATE MAY 31 1967 | |
| 25b. REGISTRAR'S SIGNATURE James Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT.

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VR A15ME (5)
6M 1/66

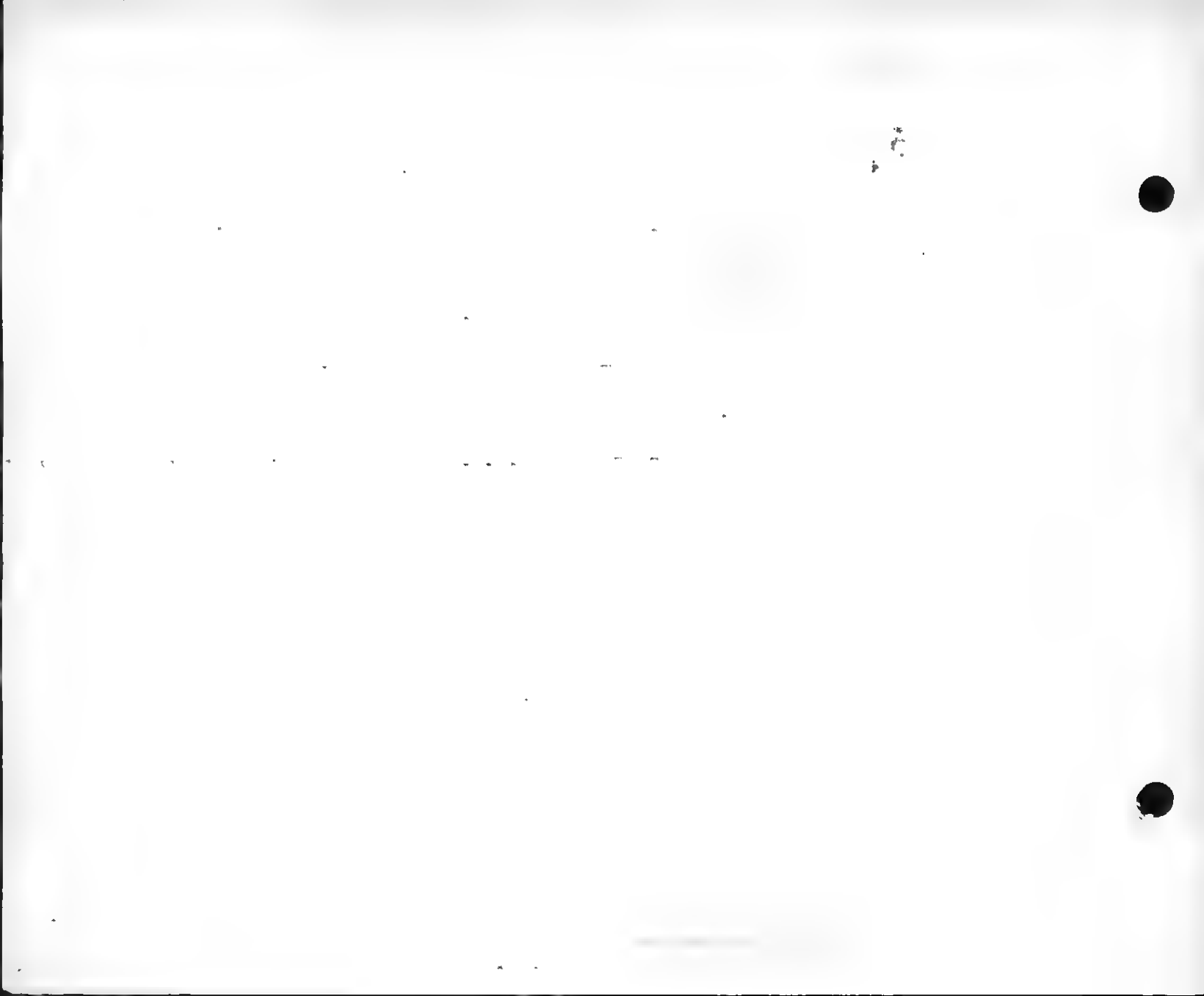
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07325

| | | | |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a STATE <u>Maryland</u> b COUNTY <u>Washington</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c LENGTH OF STAY N 1b <u>Hagerstown</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>406 Linganore, Ave.</u> | | d STREET ADDRESS <u>406 Linganore, Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Kathleen</u> Last <u>Murray</u> | | 4 DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 67</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Jan. 3, 1901</u> |
| 9 AGE (In years last birthday) yrs <u>66</u> | | 10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 12 KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 13 BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> | | 14 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15 FATHER'S NAME <u>Joseph G. Zimmerman</u> | | 16 MOTHER'S MAIDEN NAME <u>Bertha Arbelia Baker</u> | |
| 17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 18 SOCIAL SECURITY NO <u>214-09-0693</u> | |
| 19 INFORMANT <u>Mr. D.C. Murray</u> | | Address <u>406 Linganore Ave. Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Basal skull fracture and broken neck</u> DUE TO (b) <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (a) <u> </u> (b) <u> </u> (c) <u> </u> | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. was depressed and under psychiatric care</u> | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pt. climbed out of third-story window and fell to concrete sidewalk</u> | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <u>2-4</u> <u>xx</u> <u>5/26</u> <u>67</u> | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u> | | 20f (City or town) (County) (State) <u>Hagerstown Wash. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H. N. Weeks</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>580 Northern Ave.</u> Address (Street, city, town, or county) <u>Hagerstown, Md.</u> | |
| 22. DATE SIGNED <u>5/26/67</u> | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>5/28/67</u> | |
| 23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u> | |
| 24 FUNERAL DIRECTOR <u>Wm. Arthur</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25a REC'D BY REGISTRAR <u>MAY 31 1967</u> | |
| | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

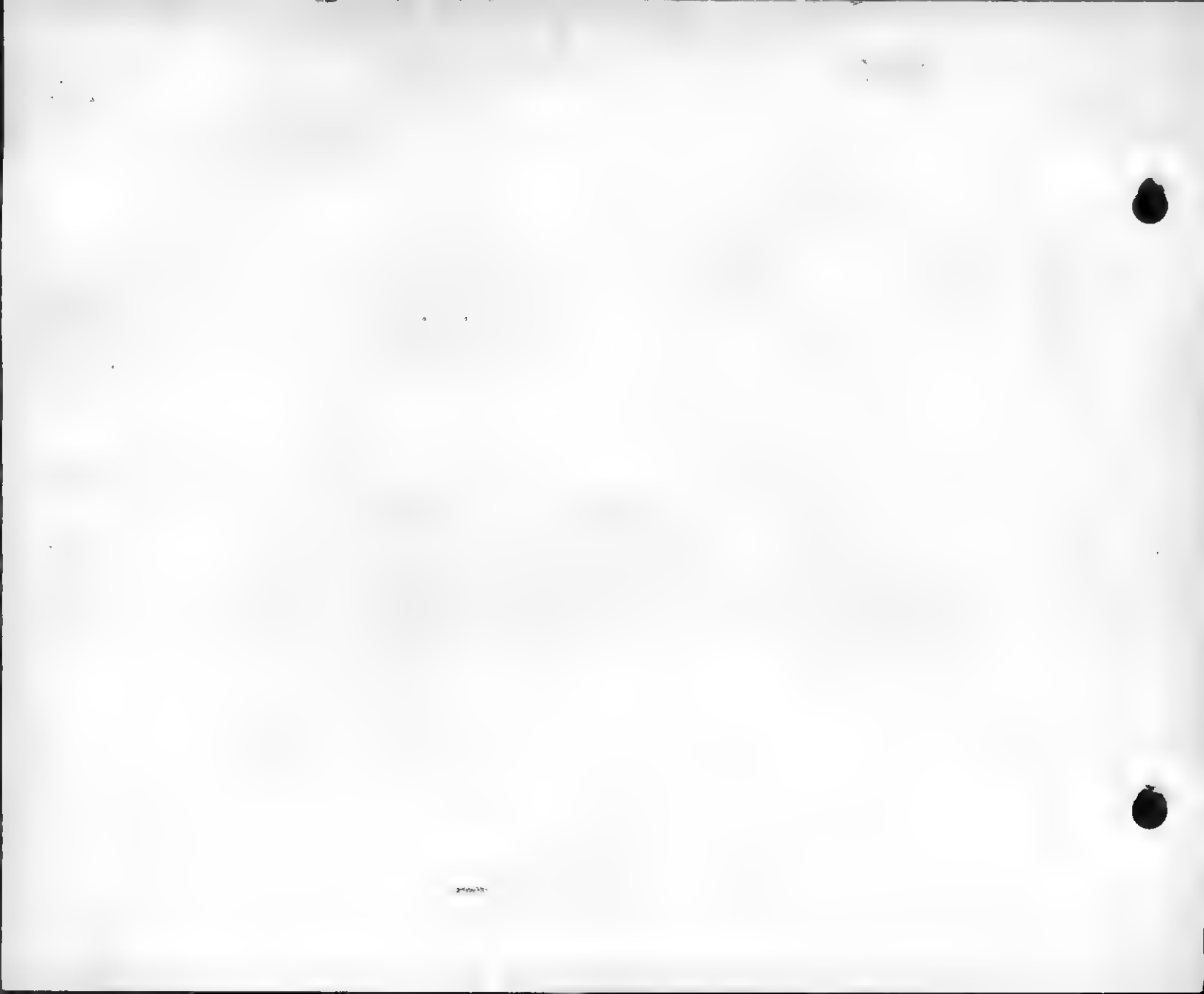
07349

CERTIFICATE OF DEATH

07326

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK | |
| d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) HOME | | d. STREET ADDRESS RURAL 2 | |
| 3 NAME OF DECEASED (Type or print) First MARIE Middle ELIZABETH Last MYERS | | 4 DATE OF DEATH Month 5 Day 4 Year 19 67 | |
| 5 SEX F | 6 COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12.11.15 |
| 9 AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) FULTON COUNTY PENNA | | 12 CITIZENSHIP OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME OLIVER M DIVELBLISS | | 14 MOTHER'S MAIDEN NAME IVY DESHONG | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT PAUL H MYERS RURAL 2 HANCOCK MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Obesity | | INTERVA. BETWEEN ONSET AND DEATH 1 hr 12 yrs 6 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m p m 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from 4/13/67 , 19__, to 4/14/67 , 19__, that (I) (we) last saw the deceased alive on 4/14/67 , 19__, and that death occurred at 10:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE FB Thomas III MD | | 22b. DATE SIGNED 5/8/67 | |
| 22c. PHYSICIAN'S NAME (Type) FB Thomas III MD | | 22d. ADDRESS Hancock, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 5.8.67 | 23c. NAME OF CEMETERY OR CREMATORIUM CEDAR LAWN MEMORIAL | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD |
| 24 FUNERAL DIRECTOR Houmard & Shore Hancock Md | | 25a. REC'D BY REGISTRAR MAY 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07350

CERTIFICATE OF DEATH

07327

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN b 19 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home Inc | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Loudon c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovetttsville d. STREET ADDRESS Route # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE LAVENIA MYERS | | 4. DATE OF DEATH Month Day Year May 21 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 2 1896 9. AGE (in years last birthday) yrs 70 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse 10b. KIND OF BUSINESS OR IND. STRY Nursing |
| 11. BIRTHPLACE (County & State, or foreign country) Waterford Loudon Co Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Edward Myers | | 14. MOTHER'S MAIDEN NAME Essie Lathan Rollins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 430-30-7701A | |
| 17. INFORMANT Mark G. Wagner | | Address 2570 Virginia Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 hours | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5-16-67 to 5-21-67 , that (I) (we) last saw the deceased alive on 5-21-67 , and that death occurred at 10:40 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE E.W. Ditto Jr | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) E.W. Ditto Jr | | 22d. ADDRESS 215 W. Washington St Hagerstown Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/24/67 | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | 23d. LOCATION (City or Town) (County) (State) Lovetttsville Loudon Co Va |
| 24. FUNERAL DIRECTOR Andrew K. Coffman | | 25a. REG'D BY REGISTRAR MAY 23 1967 DATE | |
| Address Hagerstown Md | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



07351

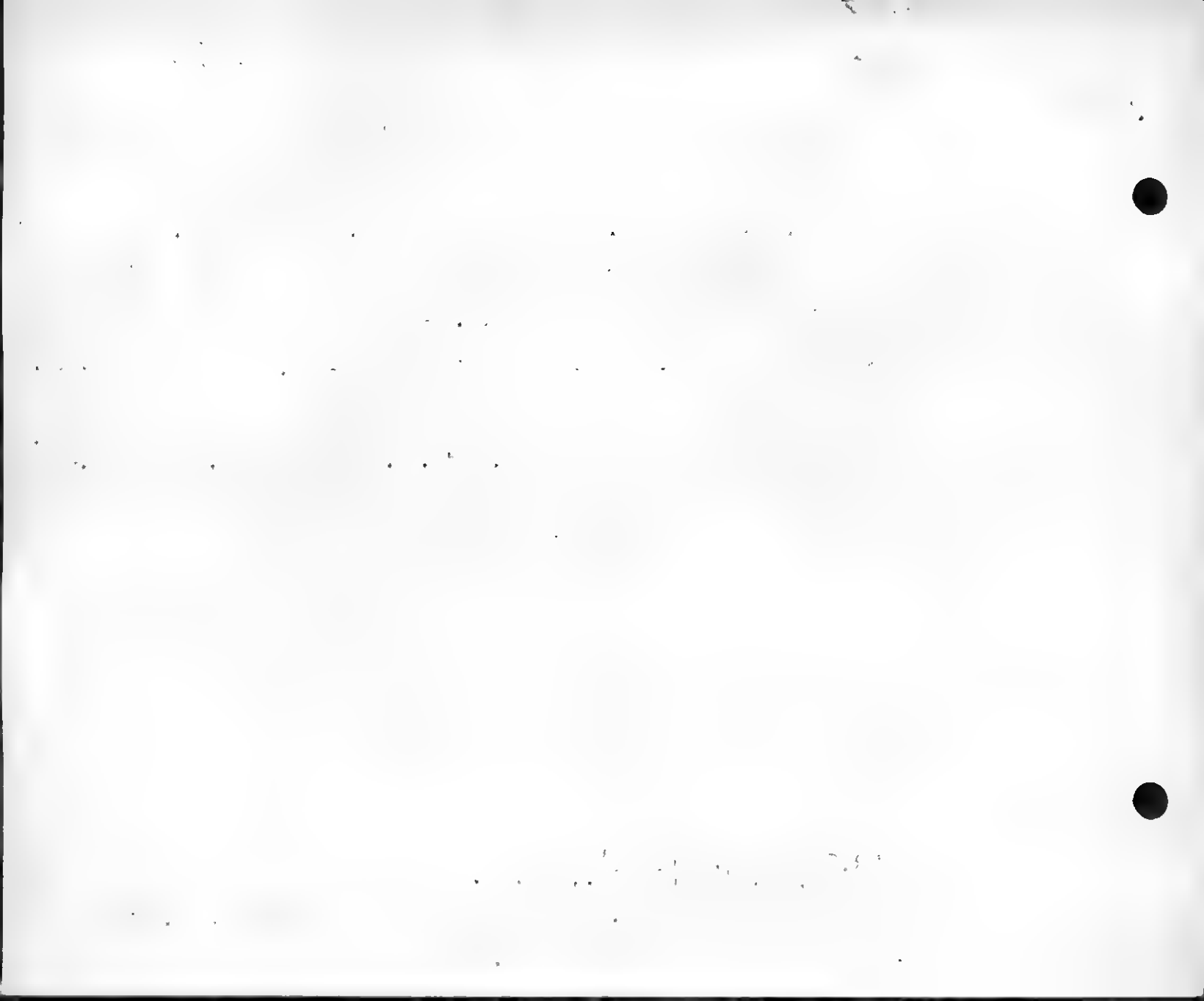
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07328

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

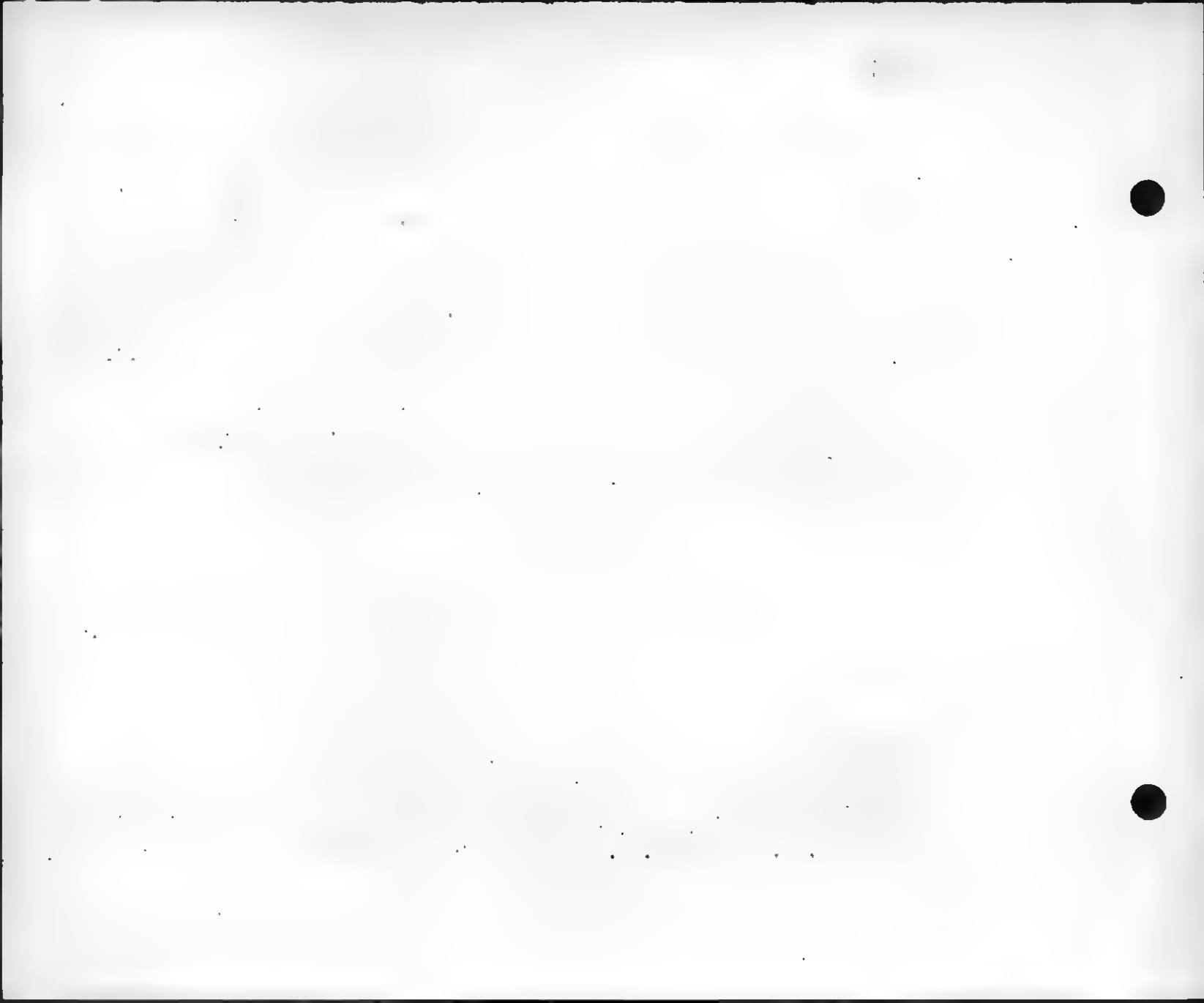
| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN b. years | |
| d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) 350 E. Washington St. | | d. STREET ADDRESS 350 E. Washington St. | |
| 3. NAME OF DECEASED (Type or print) Elmer Leroy Obitts | | 4. DATE OF DEATH Month May Day 14 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 7-1908 |
| 9. AGE (In years last birthday) 58 yrs | | 10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min | |
| 11. BIRTH-PLACE (State or foreign country) Williamsport, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Obitts | | 14. MOTHER'S MAIDEN NAME Stella Wolfe | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWar II | | 16. SOCIAL SECURITY NO 217-07-7459 | |
| 17. INFORMANT Mrs. Eliz. I. Obitts | | Address Frederick, Md. 256 S. Carroll St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombotic occlusion anterior descending Lt & Rt coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Severe coronary atherosclerosis (b) Interval between onset and death 30-50 min (c) 10-15 yrs | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration of gastric contents | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, factory, street, office bldg, etc) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above. He had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward W. Ditto III M.D. | | 22. DATE SIGNED 5-15-67 | |
| EXAMINER'S NAME (Type) DR. EDWARD W. DITTO III | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF May 17-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701 | |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS Whitmore Frederick, Md. 21701 | | DATE MAY 19 1967 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|----------------------------------|--------------------------------------|---|--|--|--|---|--|---|--|
| 07352 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 07329 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. LENGTH OF STAY IN ID <u>4 weeks</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u> | | | | | | d. STREET ADDRESS <u>13 E. Frederick Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>THELMA AMELIA PALMER</u> | | | | | | 4. DATE OF DEATH <u>May 3 1967</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 23 1909</u> | | 9. AGE (In years last birthday) <u>57 yrs.</u> | | IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>9</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>David Walt Young</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Anna May Little</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr. Van D. Palmer</u> Address <u>13 E. Frederick Street Williamsport Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Tumor (left)</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos 3</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 29</u> , 19 <u>65</u> , to <u>May 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> , 19 <u>67</u> , and that death occurred at <u>8:30M</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>M. E. Byrkit, M. D.</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>May 4, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit, M. D.</u> | | | | | | 22d. ADDRESS <u>28 West Potomac Street, Williamsport, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>May 6-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | | 23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR <u>MAY 8 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

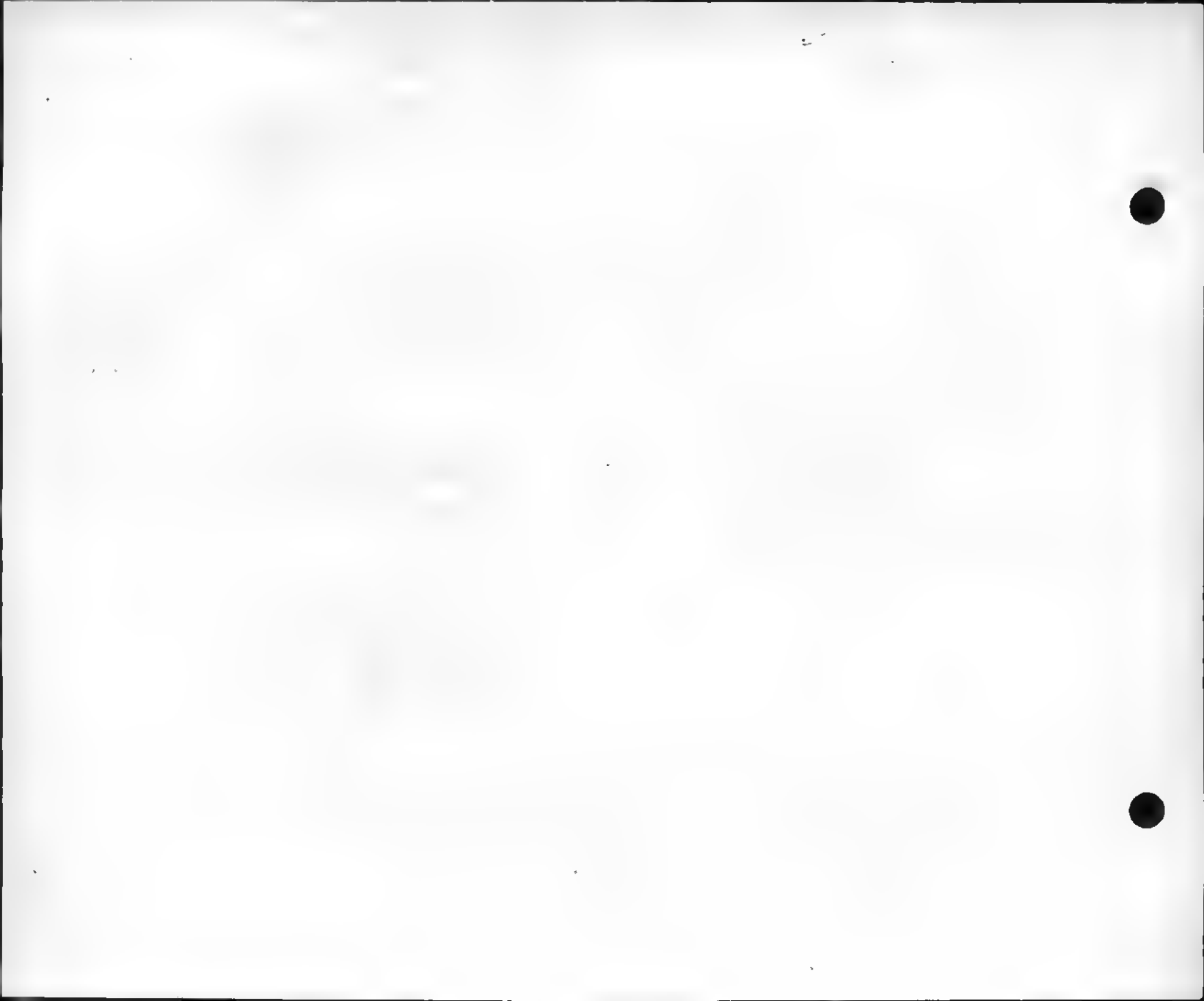
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07353

CERTIFICATE OF DEATH

07330

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY in 1b 55 YEARS | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | d. STREET ADDRESS 935 THE TERRACE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle WESLEY Last PANGBORN | | | | 4. DATE OF DEATH Month MAY Day 20 Year 1967 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 29, 1880 | | 9. AGE (In years last birthday) 86 yrs | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | 11. IF UNDER 24 HRS Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRESIDENT | | 10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING FIRM | | 11. BIRTHPLACE (County & State, or foreign country) BROOKLYN, NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES T. PANGBORN | | | | 14. MOTHER'S MAIDEN NAME ANNA MORRIS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-09-5943 | | 17. INFORMANT MRS. HELEN FISHER, 635 OAK HILL AVE. HAGERSTOWN, MARYLAND. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIOSCLEROTIC C-V disease DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 20 YRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Nov. 1965 , to MAY 20, 1967 , that (I) (we) last saw the deceased alive on MAY 20, 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John A. Moran | | | | 22b. DATE SIGNED MAY 22, 1967 | | 22c. PHYSICIAN'S NAME (Type) DR. JOHN A. MORAN, M.D. | |
| 22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN, MD. | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 5/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | | | 25a. REC'D BY REGISTRAR MAY 24 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

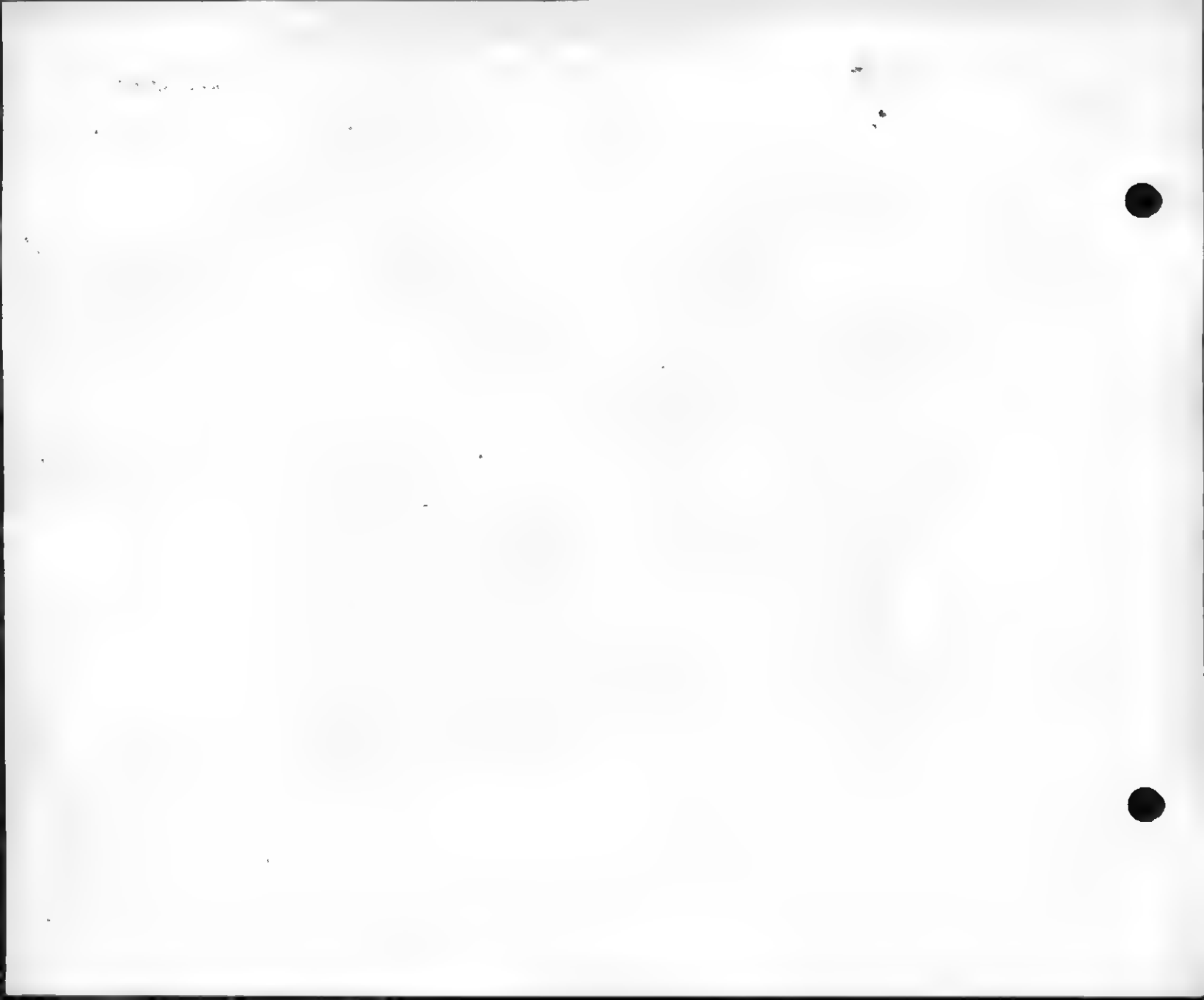
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07354

CERTIFICATE OF DEATH

07332

| | | | | | |
|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Wash. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN TB 24 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | d. STREET ADDRESS 134 Broadway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last HERMAN ERNEST PECHART | | | 4. DATE OF DEATH Month Day Year May 15, 19 67 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-15-1918 | | 9. AGE (In years last birthday) 48 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) driver | | 10b. KIND OF BUSINESS OR INDUSTRY delivery service | | 11. BIRTHPLACE (County & State, or foreign country) Boiling Springs, Pa | |
| 13. FATHER'S NAME Edward T. Pechart | | | 14. MOTHER'S MAIDEN NAME Laura Fahrenstock | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 183-12-1990 | | 17. INFORMANT Address Mrs. Betty Pechart, Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor - brain stem - type 201X DUE TO not determined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3-31 , 19 67 to 5/15 , 19 67 , that (I) (we) last saw the deceased alive on 5/15 , 19 67 , and that death occurred at 10:57 P.M., from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE George Jennings | | 22b. DATE SIGNED 5/17/67 | | 22c. PHYSICIAN'S NAME (Type) George Jennings | |
| 22d. ADDRESS 318 N. Pot. St., Hagerstown, Md. | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-18-67 | 23c. NAME OF CEMETERY OR CREMATORY Springville, Cemetery | | 23d. LOCATION (City or Town) (County) (State) Boiling Springs, Pa. | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR MAY 19 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

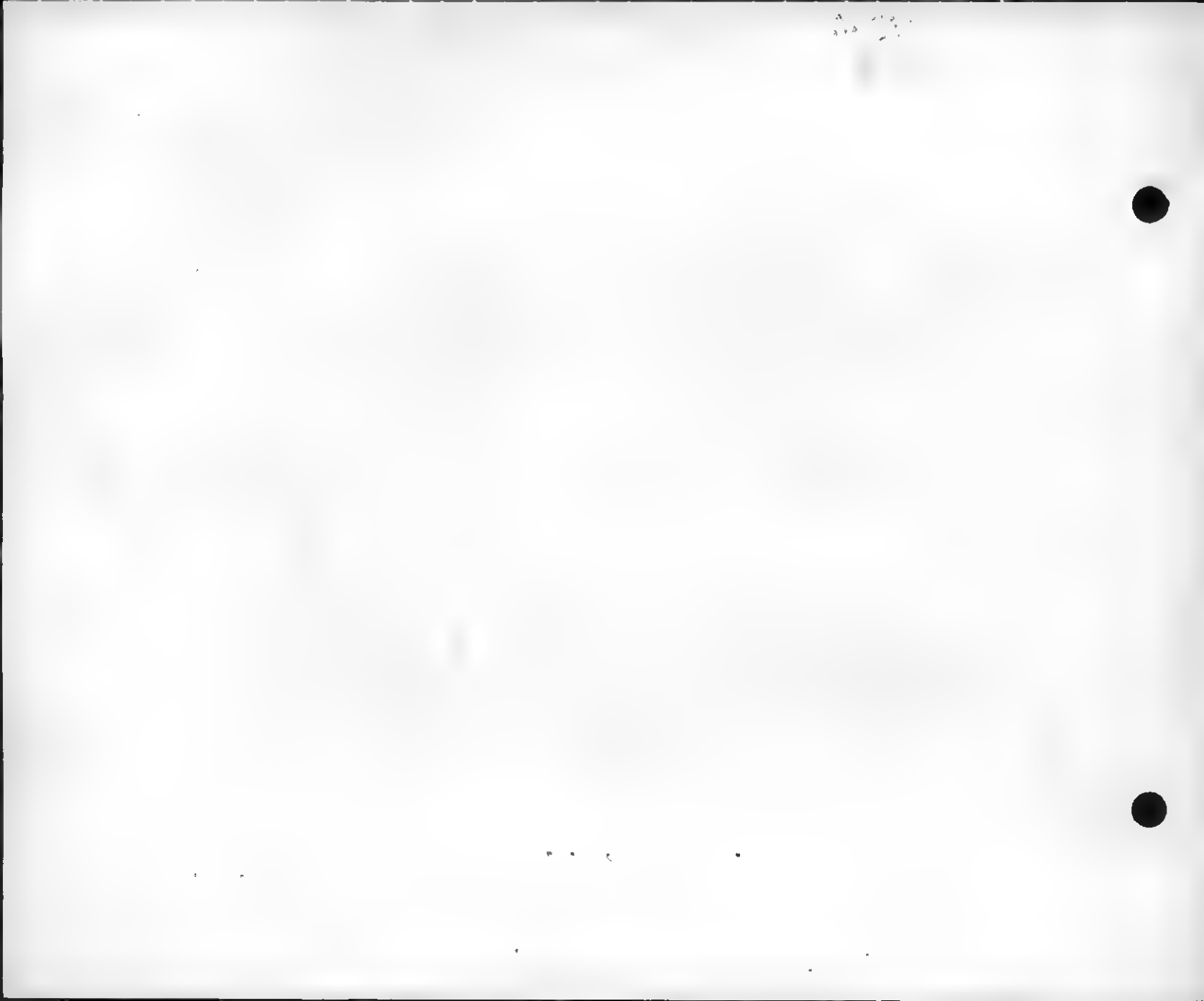
07355

CERTIFICATE OF DEATH

07331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 2 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | e. STREET ADDRESS Fahrney Keedy Home | |
| 3 NAME OF DECEASED (Type or print) Harriett Grosh Remsberg | | 4. DATE OF DEATH Month May 15, 1967 Day 15 Year 19 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Aug. 31, 1882 |
| 9 AGE (In years last birthday) 84 yrs | | 10 IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min 15 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House Wife | | 10b KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11 BIRTHPLACE (County & State, or foreign country) Jeffsville, Penna. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ruben Grosh | | 14. MOTHER'S MAIDEN NAME Amelia Lovering | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO None | |
| 17 INFORMANT Mrs Gladys Hoffman | | 18 ADDRESS 943 Forest Drive Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Profound ulcer & hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | INTERVAL BETWEEN ONSET AND DEATH Uncertain |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease & atrial fibrillation | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5/15, 1967 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/15, 1967 , and that death occurred at 10 P. M. from causes and on the date stated above | | | |
| 22a. SIGNATURE John H. Hornbaker | | 22b. DATE SIGNED 5-16-67 | |
| 22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D. | | 22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/18/67 | 23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | 23d. LOCATION (City or Town) (County) (State) Middletown Maryland |
| 24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Maryland. | | 25a. REG'D BY REGISTRAR MAY 22 1967 DATE | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #3

CERTIFICATE OF DEATH

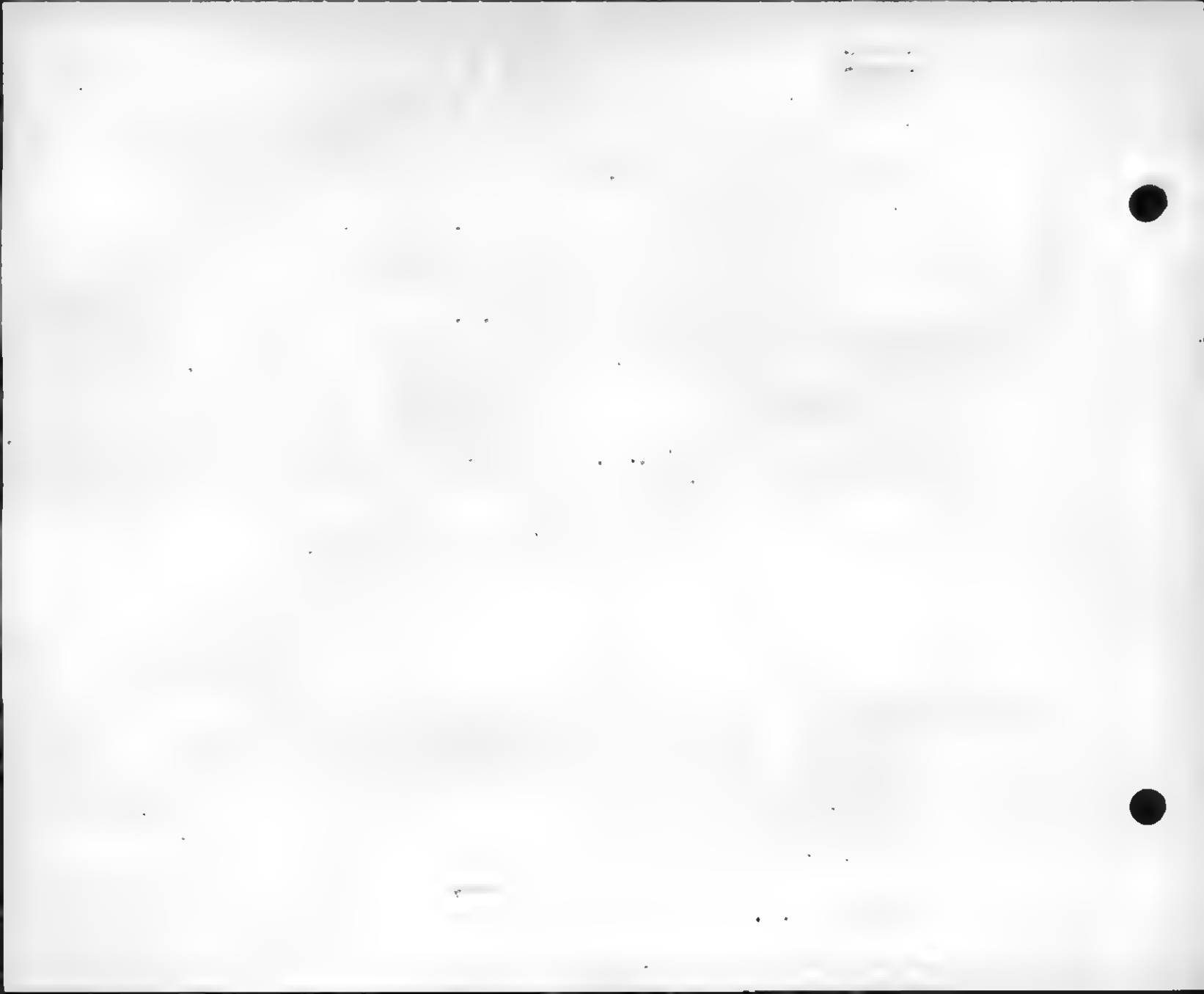
07356

07333

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b COUNTY WASHINGTON | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK | | c LENGTH OF STAY IN 1b 80.YRS | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Cora Mabel Richards | | 4. DATE OF DEATH Month 5 Day 6 Year 19 67 | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2.6.79 |
| 9 AGE (In years last birthday) yrs. 88 | | 10 F UNDER 1 YEAR Months Days IF UNDER 24 HRS hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY SCHOOL | |
| 11. BIRTHPLACE (County & State or foreign country) FULTON COUNTY PENNA. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN BROOKE | | 14 MOTHER'S MAIDEN NAME RACHEL H GREGORY | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 212.14.7860D | |
| 17 INFORMANT MRS H. EDWIN BLAIR | | Address HAGERSTOWN MD. 673 OAK HILL AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AHD 4200 DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs |
| PART II OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/24/67, 19 to 5/6/67, 19, that (I) (we) last saw the deceased alive on 5/6/67, 19, and that death occurred at 12:25 PM, from causes on and the date stated above. | | | |
| 22a SIGNATURE FB Thomas III M.D. | | 22b DATE SIGNED 5/8/67 | |
| 22c PHYSICIAN'S NAME (Type) FB Thomas III M.D. | | 22d ADDRESS Hancock, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF 5.9.67 | 23c NAME OF CEMETERY OR CHURCH PRESBYTERIAN | 23d LOCATION (City or Town) (County) (State) HANCOCK WASHINGTON MD. |
| 24 FUNERAL DIRECTOR Howard F. Stone, Hancock, Md. | | 25a REC'D BY REGISTRAR MAY 11 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

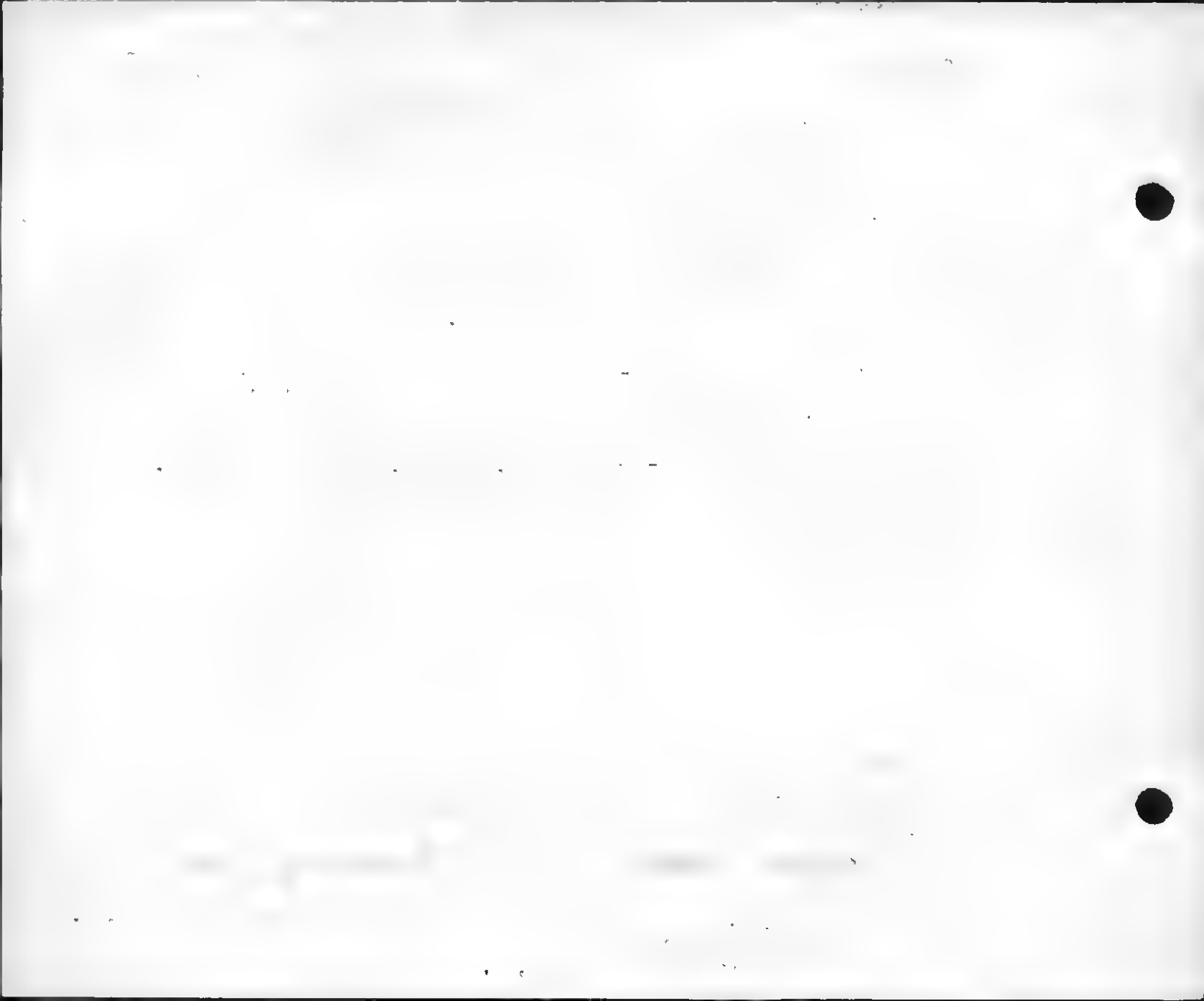
07357

CERTIFICATE OF DEATH

07334

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hagerstown</u> c LENGTH OF STAY IN TB <u>5 weeks</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u> d STREET ADDRESS <u>None</u> e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) <u>Walter Earl Shank</u> | | | 4 DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1967</u> | | | | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Oct. 8, 1890</u> | 9 AGE (n years last birthday) <u>76</u> yrs IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Core Maker</u> | | |
| 10b KIND OF BUSINESS OR INDUSTRY <u>Foundry</u> | | 11 BIRTHPLACE (County & State, or foreign country) <u>Lappans Cross Rds. Md.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13 FATHER'S NAME <u>Joseph Shank</u> | | | 14 MOTHER'S MAIDEN NAME <u>Wash. Co.</u> <u>Susan Lapole</u> | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO <u>214-09-2441</u> | | 17 INFORMANT Address <u>Mrs. Walter E. Shank Cavetown, Md.</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u> | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f (City or town) (County) (State) | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>60</u> , to <u>5-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-25</u> 19 <u>65</u> , and that death occurred at <u>4:30</u> P.M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE <u>Charles F. Hess</u> | | | 22b DATE SIGNED <u>5-26-67</u> | | 22c PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u> | | |
| 22d ADDRESS <u>Smithsburg, Md.</u> | | | 22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>5/28/67</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u> | | | |
| 23d LOCATION (City or Town) (County) (State) <u>Smithsburg, Washington, Md.</u> | | 24 FUNERAL DIRECTOR <u>Wm. G. Horst</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | | | | |
| 25a REC'D BY REGISTRAR <u>MAY 31 1967</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

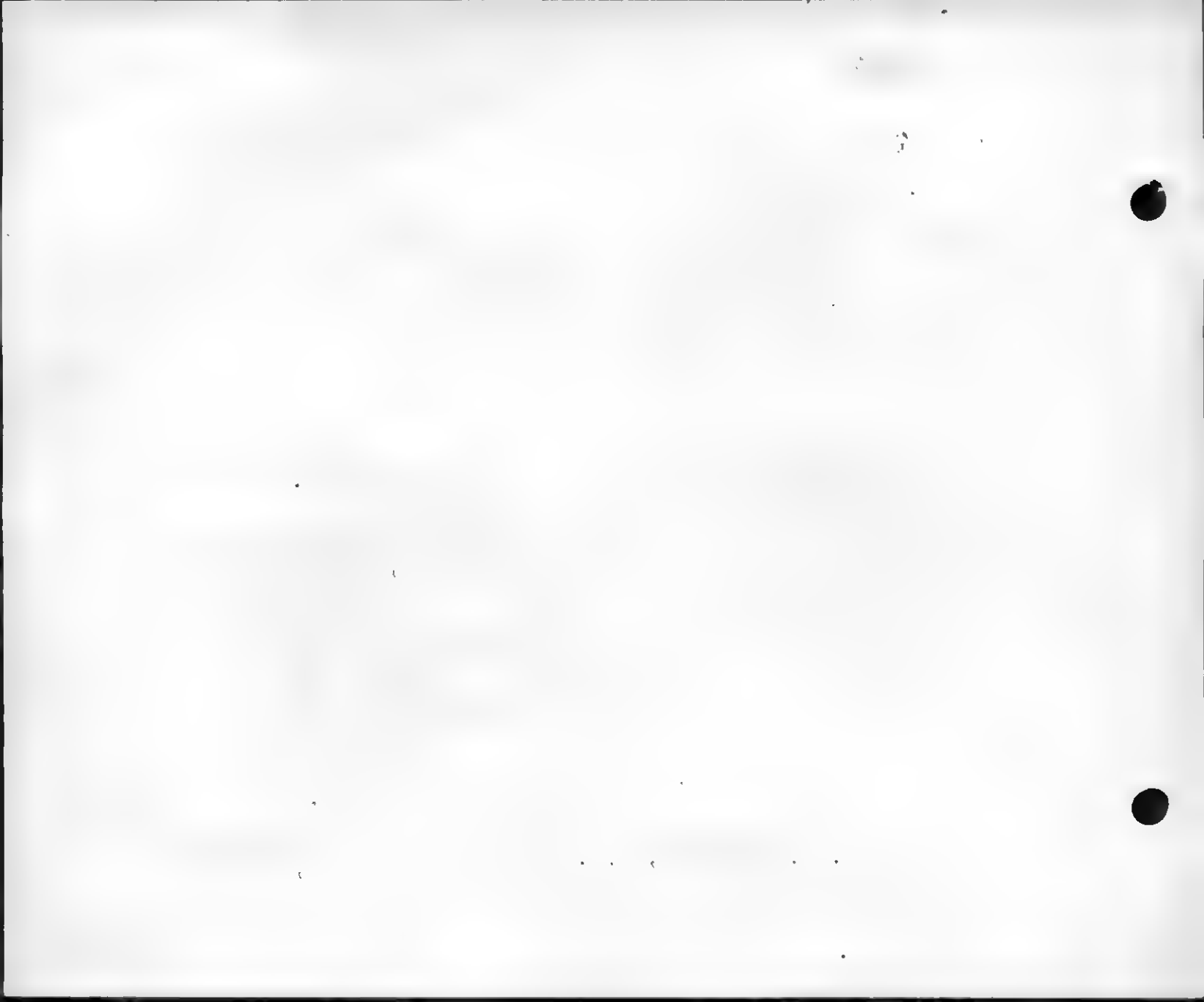
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07358

CERTIFICATE OF DEATH

07335

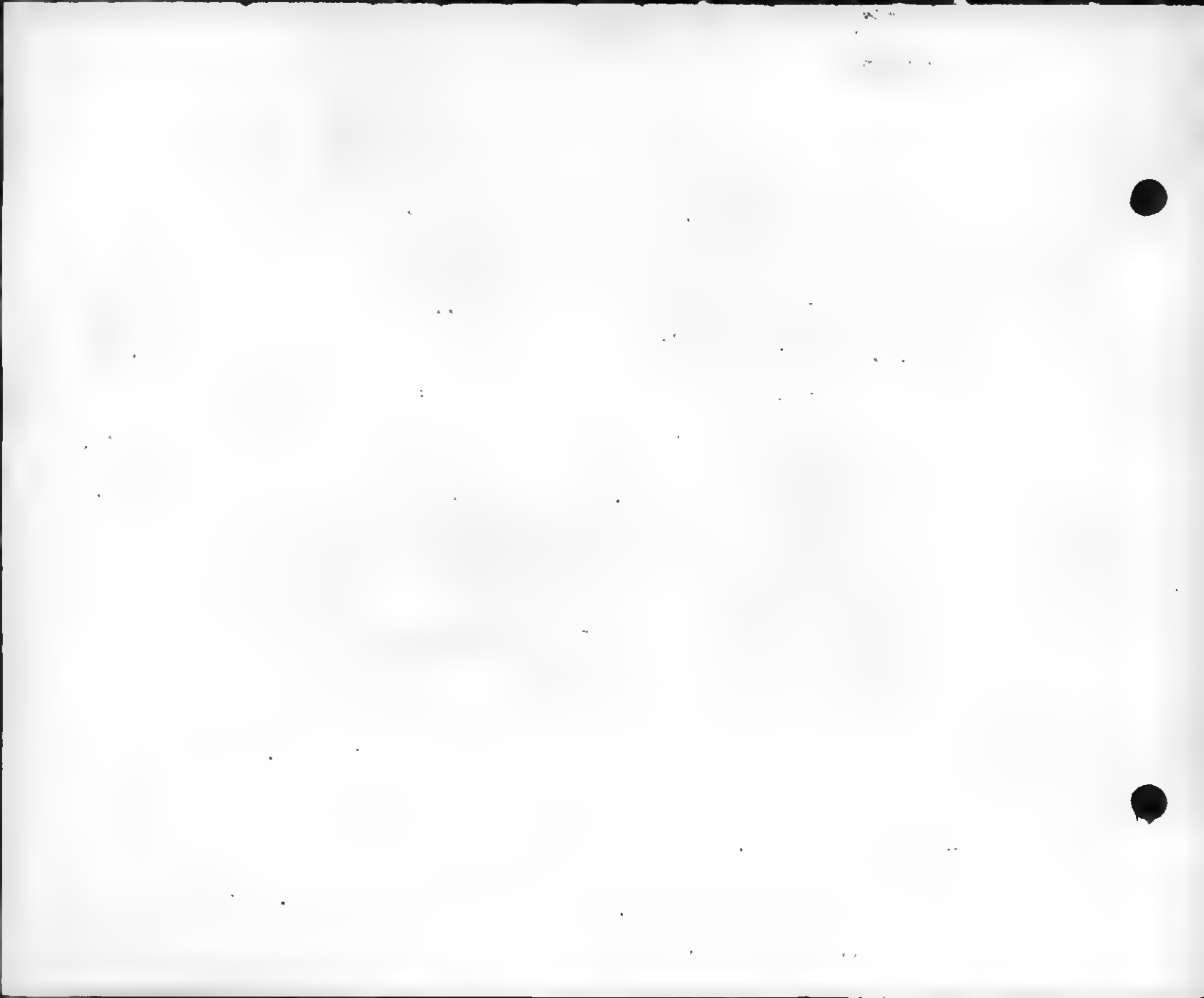
| | | | | | | | |
|--|----------------------------------|--|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN TOWN <u>Years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Conv. Home</u> | | | | d. STREET ADDRESS <u>206 No Colonial Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>PAKMER</u> Last <u>SHANNON</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 3 1868</u> | 9. AGE (In years last birthday) <u>99</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | IF UNDER 24 HRS Hours <u> </u> Min <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u> | | 12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George A. Palmer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sallie Hill</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>None</u> | | 17. INFORMANT <u>Mrs Lucille Stchison</u> | | Address <u>Dr 206 N. Colonial</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease with</u> DUE TO <u>vascular hypertension, arteriosclerotic</u> (c) <u>Indefinite</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>67</u> , to <u>May 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 20</u> , 19 <u>67</u> , and that death occurred at <u>2:15 A.</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>B. B. Kneisley</u> | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22b. DATE SIGNED <u>5/29/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> | | 22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, or other disposition <u>Entombment</u> | | 23b. DATE THEREOF <u>5/30/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Mem. Park</u> | | 23d. LOCATION (City or town) (County) (State) <u>Frederick Frederick Co Md</u> | |
| 24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> | | | | 25a. REC'D BY REGISTRAR <u>MAY 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 07359 | | | | CERTIFICATE OF DEATH | | | | 07336 | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN 1b <u>15 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>113 S Mechanic Street</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>113 S. Mechanic Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>SILAS</u> Middle <u>DAVIS</u> Last <u>SHIPLEY</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 67</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb.. 6 1887</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Supt. Maintenance</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>College</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Fonrose Shipley</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Griffith</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>220 18 0250</u> | | 17. INFORMANT <u>Mildred Mc Graw</u> | | Address <u>113 S. Mechanic St. Sharpsburg Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY FIBROSIS AND EMPHYSEMA</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> , 19 <u>66</u> , to <u>5/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/2/67</u> 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> on <u>5/2/67</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>R. Amarillo</u> | | | | 22b. DATE SIGNED <u>5/26/67</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>R. Amarillo</u> | | | | 22d. ADDRESS <u>Sharpsburg, Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>May 27-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Sharpsburg Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Albert L.. Leaf Williamsport Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>MAY 29 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Williams</u> | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07337

| | | | |
|---|-----------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN It <u>35 Years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2416 Virginia Ave</u> | | d. STREET ADDRESS <u>2416 Virginia Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) <u>CLIFFORD HULLEN SHOOP</u> | | 4 DATE OF DEATH <u>May 25 1967</u> 19 <u>67</u> | |
| 5. SEX <u>Male</u> | 6. CO. OR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 16 1886</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs | | 10. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Mt Aetna Wash Co Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Levi Shoop</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Foltz</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-40-3410</u> | |
| 17. INFORMANT <u>Dallas E Shoop</u> | | Address <u>2416 Virginia Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>hypertensive arteriosclerotic C.V.D.</u> DUE TO (c) <u>years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H.N. Weeks</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>H.N. Weeks, M.D.</u> | | ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>580 Northern Ave.</u> | |
| | | Address (Street, city, town, or county) <u>Hagerstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/27/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City or town) (County) (State) <u>Hagerstown Wash Co Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> | | 25a. REC'D BY REGISTRAR <u>MAI 31 1967</u> | |
| ADDRESS <u>Funeral Home Inc</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07361

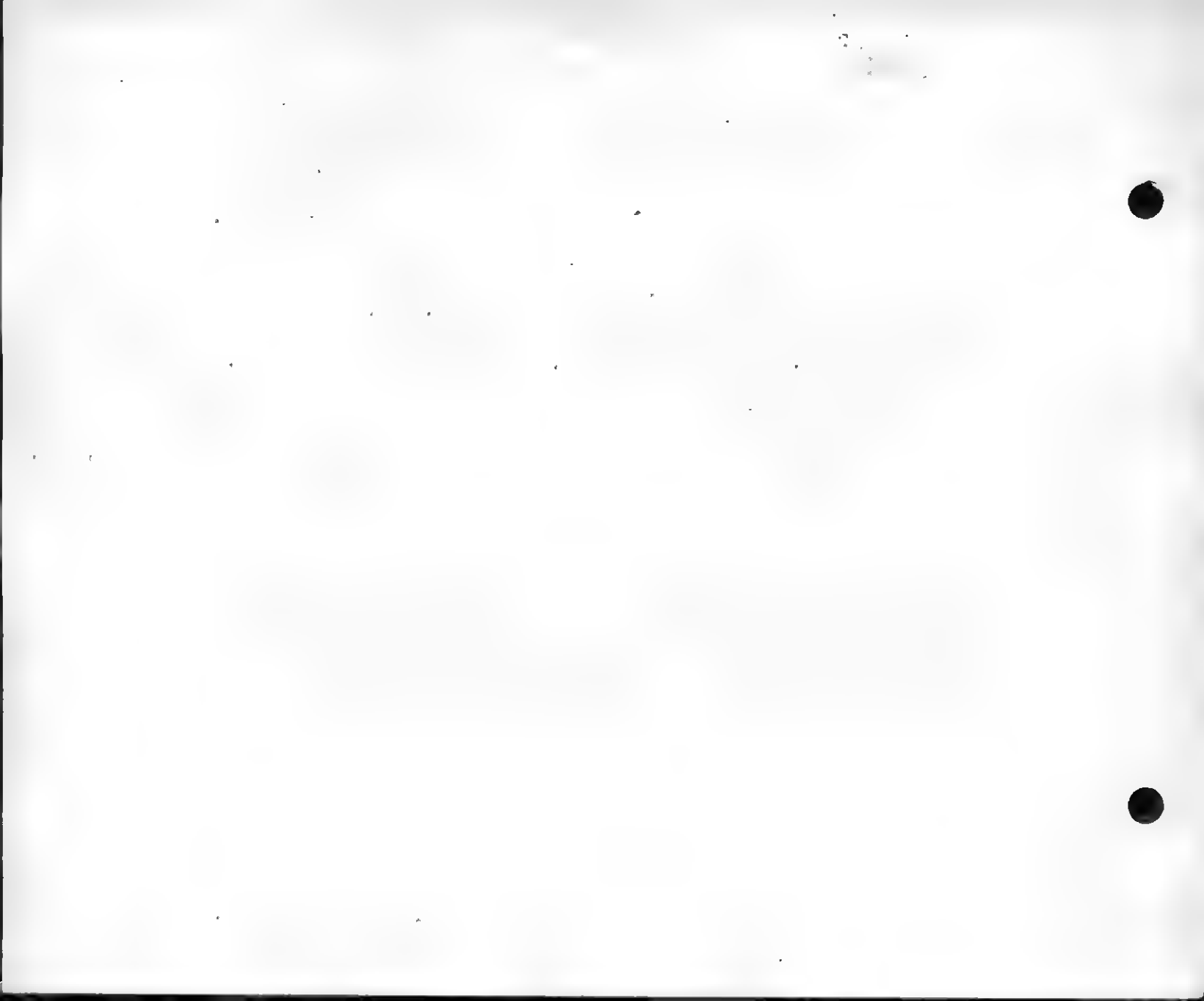
CERTIFICATE OF DEATH

07338

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admiss on) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d. STREET ADDRESS 1401 Virginia Ave. | |
| 3 NAME OF DECEASED (Type or print) First EDGAR Middle GABE Last SMITH | | 4 DATE OF DEATH Month May Day 1 Year 1967 | |
| 5. SEX male | 6 COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 11, 1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) traffic mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY snad blast. Mfg | 9 AGE (In years last birthday) yrs 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. |
| 11 BIRTHPLACE (County & State, or foreign country) Hagerstown, Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Harry Smith | | 14. MOTHER'S MAIDEN NAME Florence Gabe | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI | | 16 SOCIAL SECURITY NO 711-07-1868A | |
| 17. INFORMANT Katharine Smith | | Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Subarachnoid Hemorrhage</i></u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH 18 Hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u><i>April 30 1967</i></u> to <u><i>May 19 1967</i></u> that (I) (we) last saw the deceased alive on <u><i>April 19 1967</i></u> and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Edmund B. Hargis</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-3-67 | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | 23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland |
| 24. FUNERAL DIRECTOR Minnich Funeral Home | | 25. REC'D BY REGISTRAR MAY 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

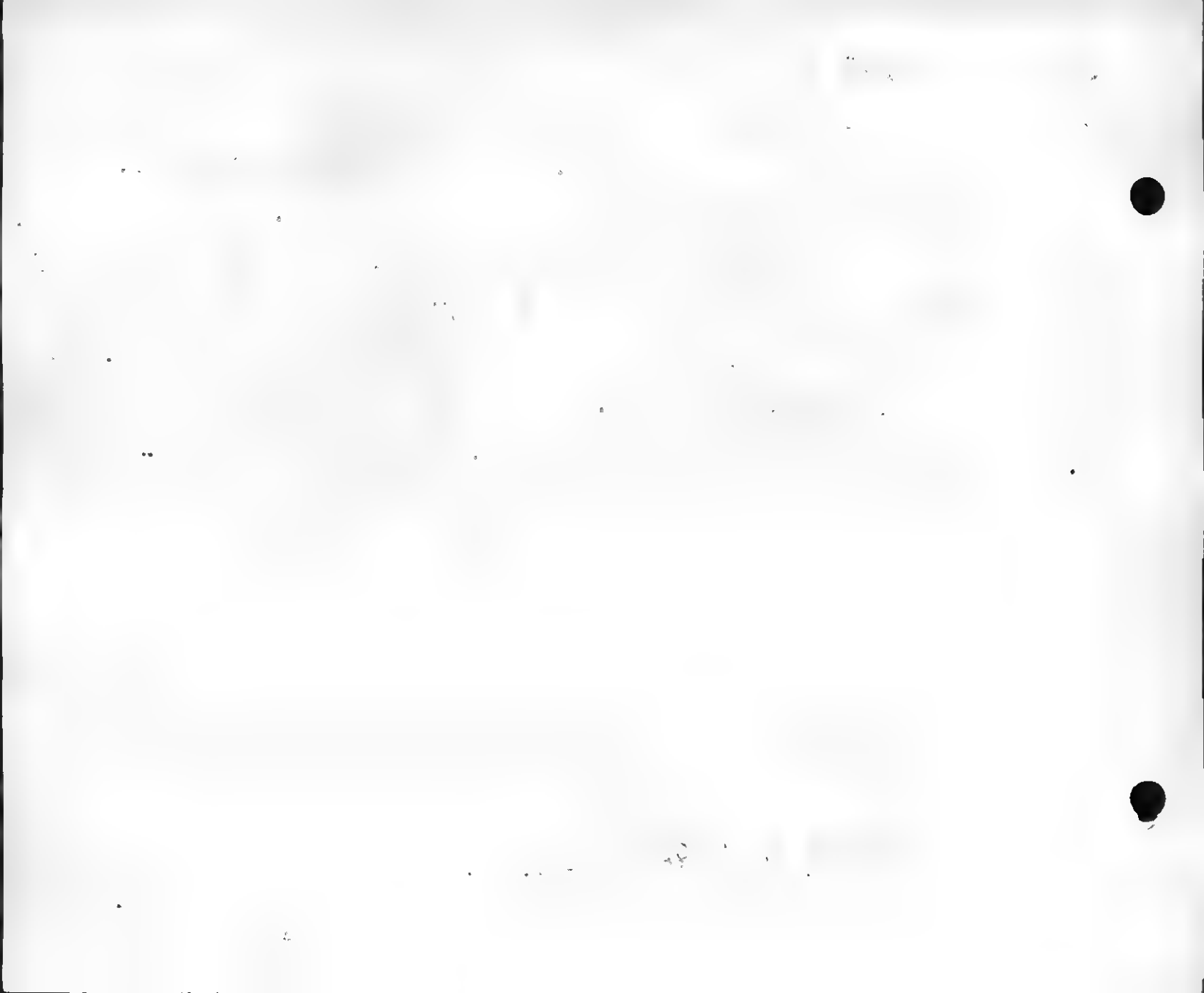
07339

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---------------------------------|---|-------------------------------------|
| 1 PLACE OF DEATH a COUNTY WASHINGTON b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | 2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON | |
| c LENGTH OF STAY IN b 1 HR. | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SMITHSBURG RT.#2 | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d STREET ADDRESS CAVE HILL RD. | |
| 3 NAME OF DECEASED (Type or print) First RALPH Middle CALVIN Last SMITH JR. | | 4 DATE OF DEATH Month MAY Day 1 Year 1967 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2/10/1967 |
| 9 AGE (In years last birthday) 11 weeks | | IF UNDER 24 HOURS Month _____ Days _____ Hours _____ Min _____ | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10b KIND OF BUSINESS OR INDUSTRY INFANT | |
| 11 BIRTHPLACE (State or foreign country) HAGERSTOWN MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME RALPH CALVIN SMITH SR. | | 14 MOTHER'S M maiden name MARY ANN WOLFINGER | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO NONE | |
| 17 INFORMANT MR. RALPH CALVIN SMITH SR. | | Address SMITHSBURG RT.#2 MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute interstitial pneumonia 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) SDH DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hr | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Edward W. Ditto III EXAMINER'S NAME (Type) 217 W. WASHINGTON ST. HAGERSTOWN, MD. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5-2-67 | |
| 22. DATE SIGNED | | | |
| 23a BURIAL, CREMATION, REINTERMENT BURIAL | | 23b DATE THEREOF 5/2/67 | |
| 23c NAME OF CEMETERY OR CREMATORY MANOR CHURCH CEM. | | 23d LOCATION (City or town) (County) (State) WASHINGTON CO. MD. | |
| 24 FUNERAL DIRECTOR W.J. Norman, Hagerstown, Md. | | 25a REC'D BY REGISTRAR MAY 4 1967 | |
| ADDRESS | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07363

CERTIFICATE OF DEATH

07340

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b LIFE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 236 NORTH MULBERRY | | d. STREET ADDRESS 236 NORTH MULBERRY | |
| 3 NAME OF DECEASED (Type or print) First Middle Last MARGARET KATHLEEN SPESSARD | | 4 DATE OF DEATH Month Day Year MAY 4 1967 | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH AUG. 19, 1902 |
| 9 AGE (In years last birthday) 64 yrs | | 10 IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM F. SEMLER | | 14. MOTHER'S MAIDEN NAME IDA J. LIZER | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17 INFORMANT RUSSELL L. SPESSARD, | | Address 232 N. MULBERRY, HAGERSTOWN, MARYLAND. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH minutes yes |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (1) (the hospital) attended the deceased from Jan 24 , 19 66 , to May 4 , 19 67 that (1) (we) last saw the deceased alive on May 1 , 19 67 , and that death occurred at 8:00 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Harold R. Titch M.D. | | 22b. DATE SIGNED MAY 6, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) DR. H. R. TRITCH, JR. M.D. | | 22d ADDRESS 302 NORTH POTOMAC ST. HAGERSTOWN, MD. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF 5/8/67 | 23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | 23d LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | 25a REC'D BY REGISTRAR MAY 9 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

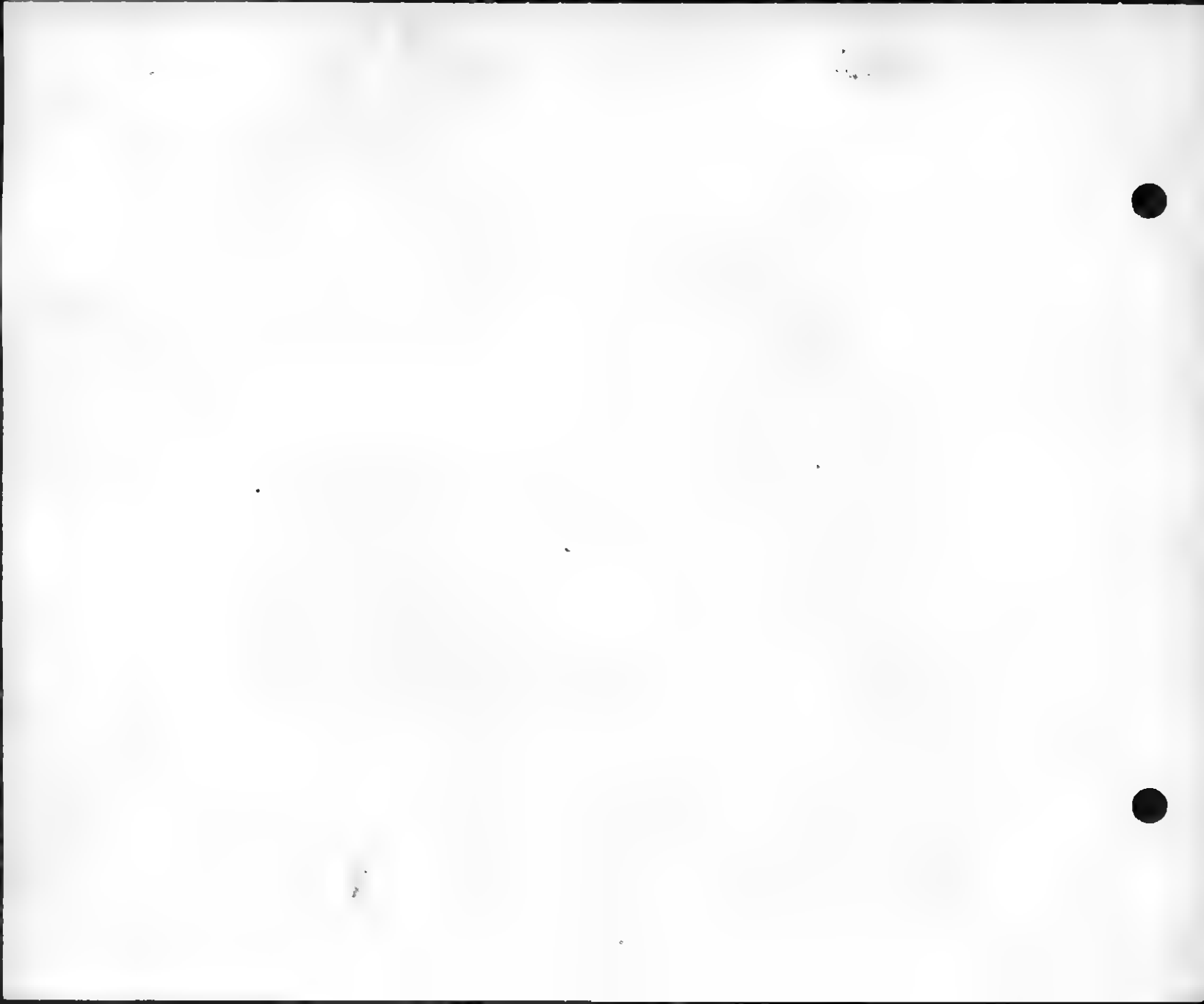
07341

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|-------------------------------------|--|---|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chewsville | | | | c. LENGTH OF STAY IN TB 4 Years | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beck Road | | | | d. STREET ADDRESS Beck Road | | | |
| 3 NAME OF DECEASED (Type or print) First HARRY Middle GORDON Last SPRECHER | | | | 4 DATE OF DEATH Month May Day 25 Year 1967 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH June 19 1923 | 9 AGE (In years last birthday) 43 yrs | IF UNDER 1 YEAR Months 1 Days 13 | | IF UNDER 24 HRS Hours 13 Min 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator | | | 10b. KIND OF BUSINESS OR INDUSTRY Mack Trucks | | 11 BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md. | | 12 CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Edgar F. Sprecher | | | | 14. MOTHER'S MAIDEN NAME Bessie Longanecker | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.#2 | | 16. SOCIAL SECURITY NO 220-16-1916 | | 17. INFORMANT Lester E. Sprecher Address 1760 Sheridan Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1) Hemorrhage from severed right femoral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2) Stab wound in left lower quadrant (c) sudden | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Life xxxk | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Life stabbed victim with hunting knife | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:20 p.m. 5/25 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Trailer | | 20f. (City or town) (County) (State) Near Chewsville Wash. Co. Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks | | M.D. Howard N. Weeks, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 5/26/67 22. DATE SIGNED | |
| EXAMINER'S NAME (Type) Howard N. Weeks, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/27/67 | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or town) (County) (State) Hagerstown Wash Co Md | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman | | | | 25a. REC'D BY REGISTRAR MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07365

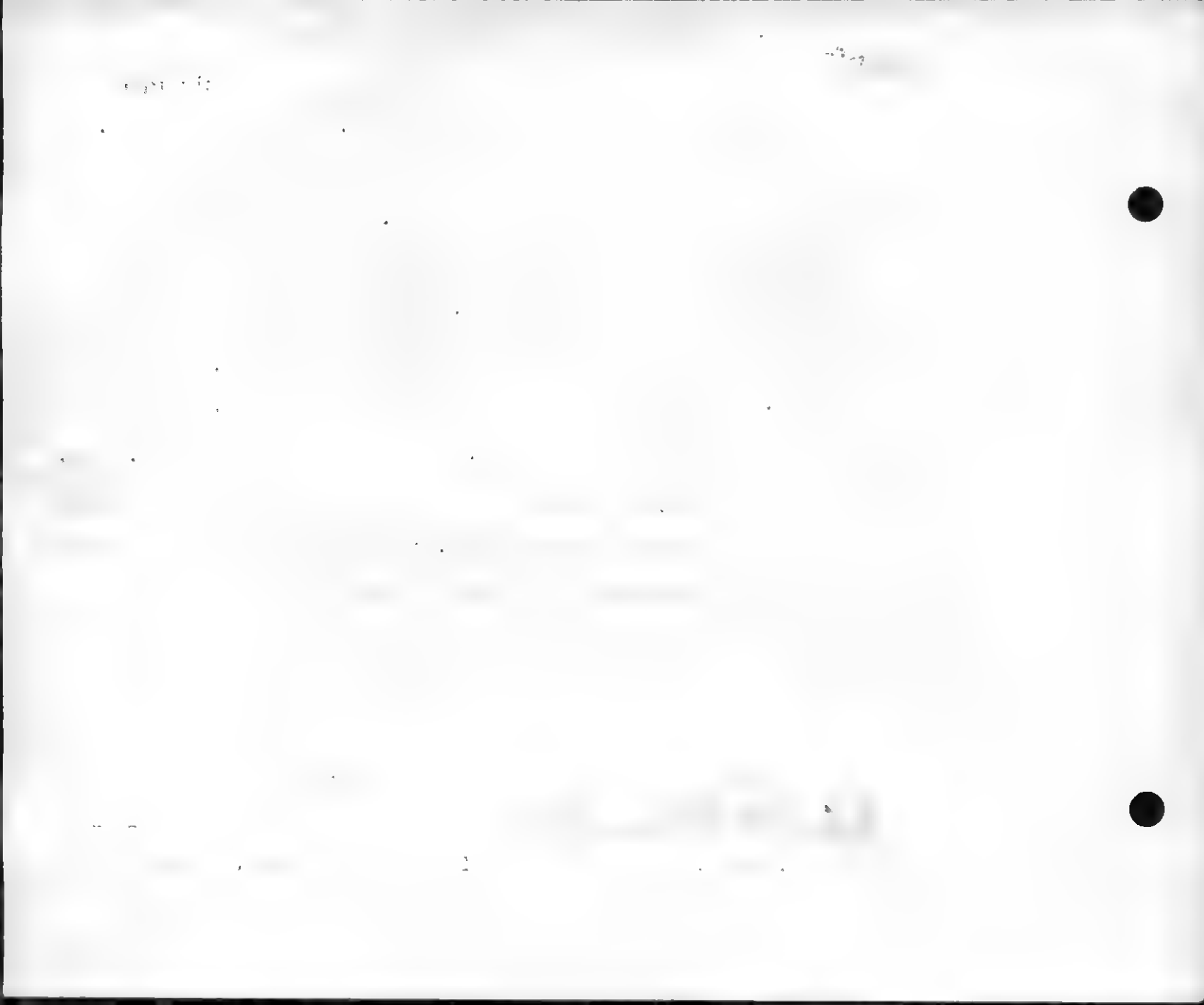
CERTIFICATE OF DEATH

07342

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY in 1b 45 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | e. STREET ADDRESS 56 E. Franklin St. | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle LESTER Last STINEBAUGH | | 4. DATE OF DEATH Month May Day 24 Year 19 67 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 21, 1904 |
| 9. AGE (n years last birthday) 62 yrs | | 10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min 12 | 11. IF UNDER 24 HRS Months 12 Days 12 Hours 12 Min 12 |
| 12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembler | | 12b. KIND OF BUSINESS OR INDUSTRY sand blast | |
| 13. FATHER'S NAME John J. Stinebaugh | | 14. MOTHER'S MAIDEN NAME Agnes L. Leakway | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Galdys Stinebaugh, Hag., Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral anoxia 1919 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Squamous cell carcinoma, pharynx with DUE TO (c) esophageal and tracheal obstruction | | INTERVAL BETWEEN ONSET AND DEATH 12 hours 9 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 24 , 19 67 , to May 24 , 19 67 , that (I) (we) saw the deceased alive on May 24 , 19 67 , and that death occurred at 12:40 PM on causes and on the date stated above. | | | |
| 22a. SIGNATURE John H. Kehne M.D. | | 22b. DATE SIGNED 5-25-67 | |
| 22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D. | | 22d. ADDRESS 1829 Ravenwood Hgts., Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-27-67 | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR MAY 31 1967 | |
| 25b. REGISTRAR'S SIGNATURE J. L. Jones | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



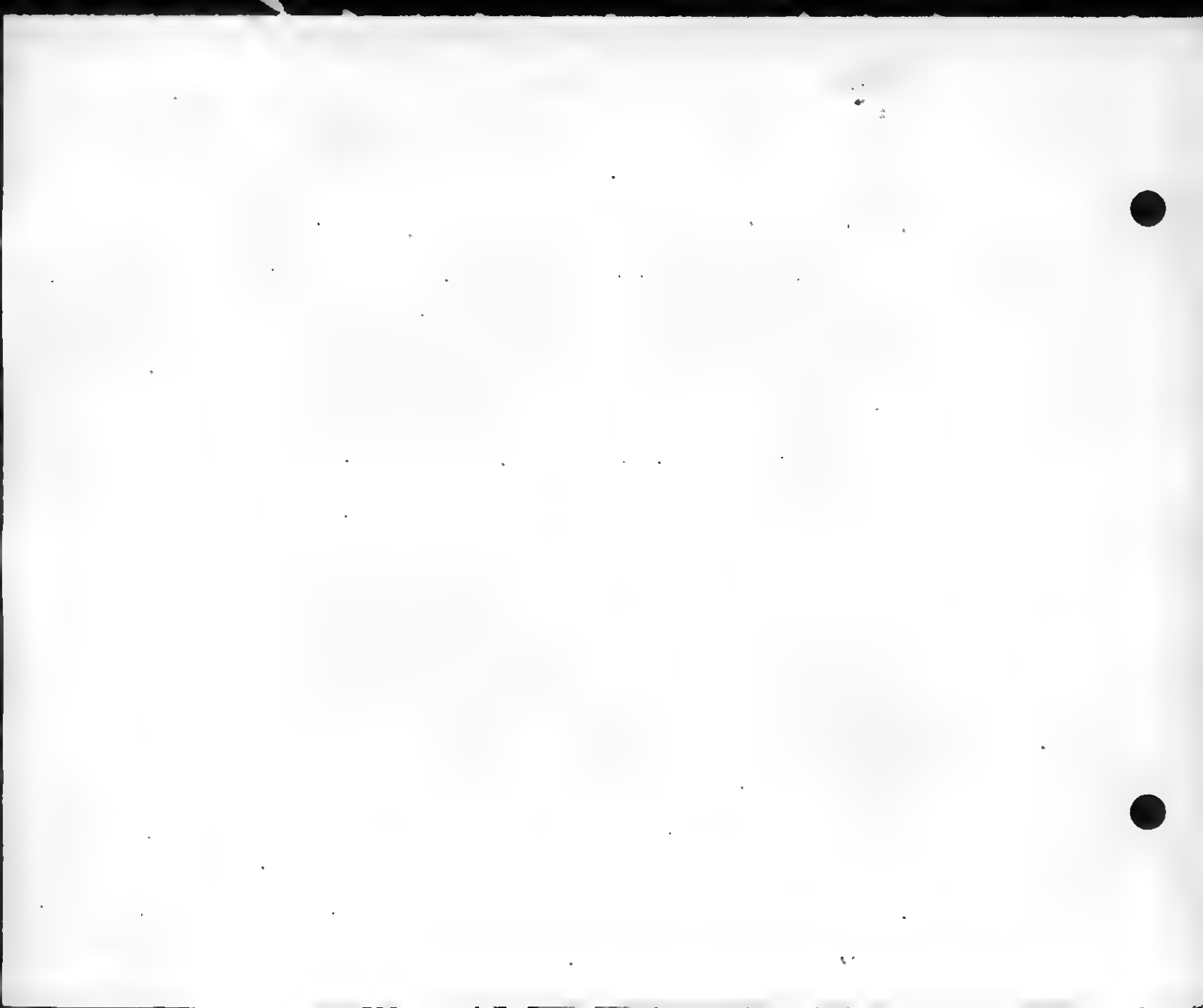
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07366 CERTIFICATE OF DEATH 07343

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN 1d <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>107 S. Mechanic St.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>107 S. Mechanic St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Margaret</u> Last <u>Stockslager</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 27 1897</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u>11</u> Days <u>4</u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Clarence Mongan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lillie Jones</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>217-16-2085</u> | | 17. INFORMANT Address <u>Mr. James Stockslager</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>11201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN DEATH</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>66</u> , to <u>5/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>67</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>R. Amarillo</u> | | | | 22b. DATE SIGNED <u>5/3/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>R. Amarillo</u> | |
| 22d. ADDRESS <u>Sharpsburg, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>May 6-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Sharpsburg Maryland</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Albert L. Leaf Williamsport Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>MAY 8 1967</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u> | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

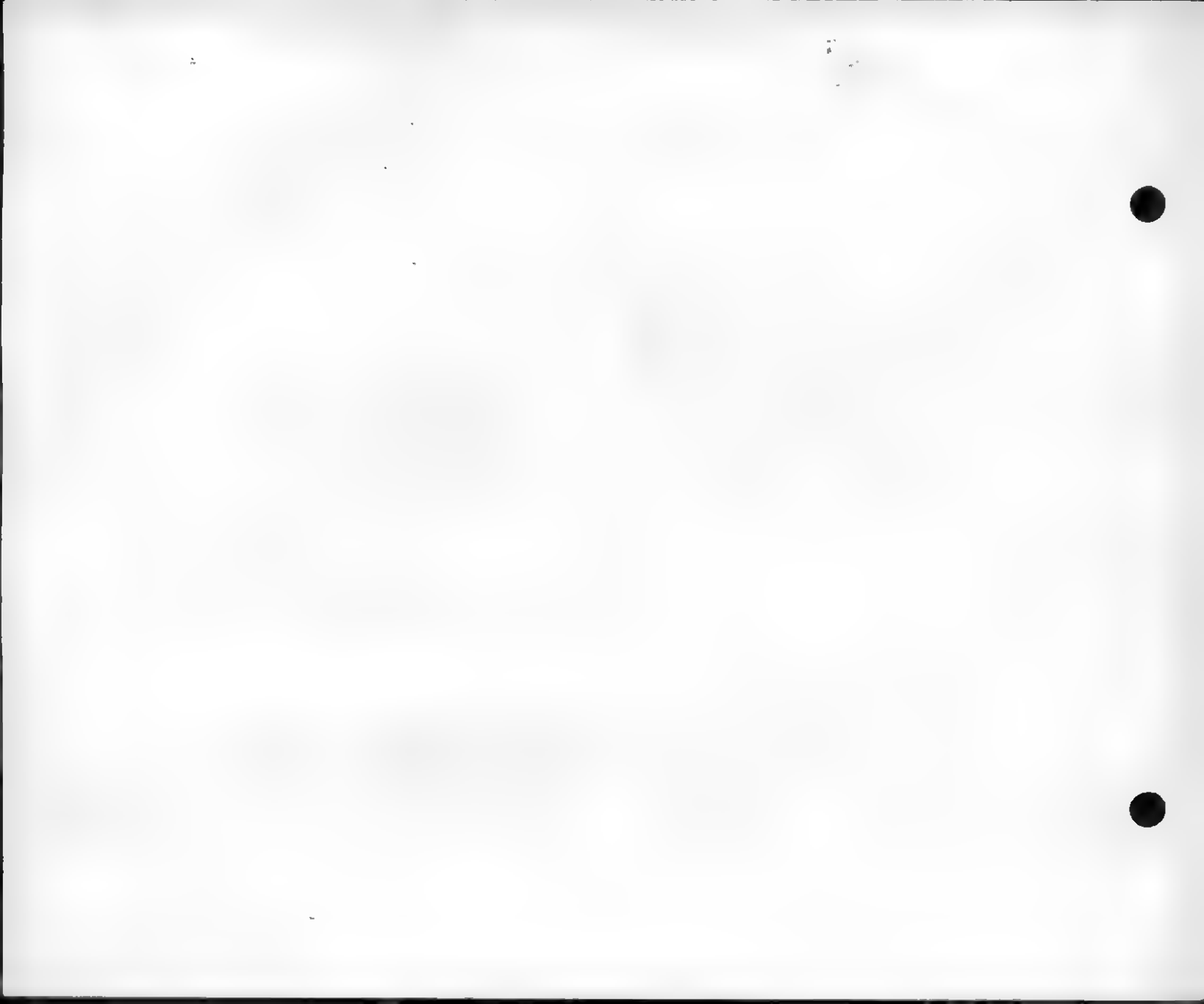
07367

07344

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clearview Nursing Home</u> | | d. STREET ADDRESS <u>257 S. Wash. St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GRACE</u> Last <u>STRITE</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/13/1873</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Amos Deatrich</u> | | 14. MOTHER'S MAIDEN NAME <u>Amelia Weaver</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u> </u> | |
| 17. INFORMANT <u>Jacob L. Deatrich - Waynesboro, Pa.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4221</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u> </u> (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1939</u> to <u>5/3</u> , 19 <u>67</u> , that (I) (we) at saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>W.C. Brewer, M.D.</u> | | 22b. DATE SIGNED <u>5/3/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u> | | 22d. ADDRESS <u>Greencastle, Pa.</u> | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or town) (County) (State) |
| <u>Burial</u> | <u>5/6/67</u> | <u>Cedar Hill</u> | <u>Greencastle, Pa.</u> |
| 24. FUNERAL DIRECTOR <u>A.E. Mummich - Greencastle, Pa.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 8 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

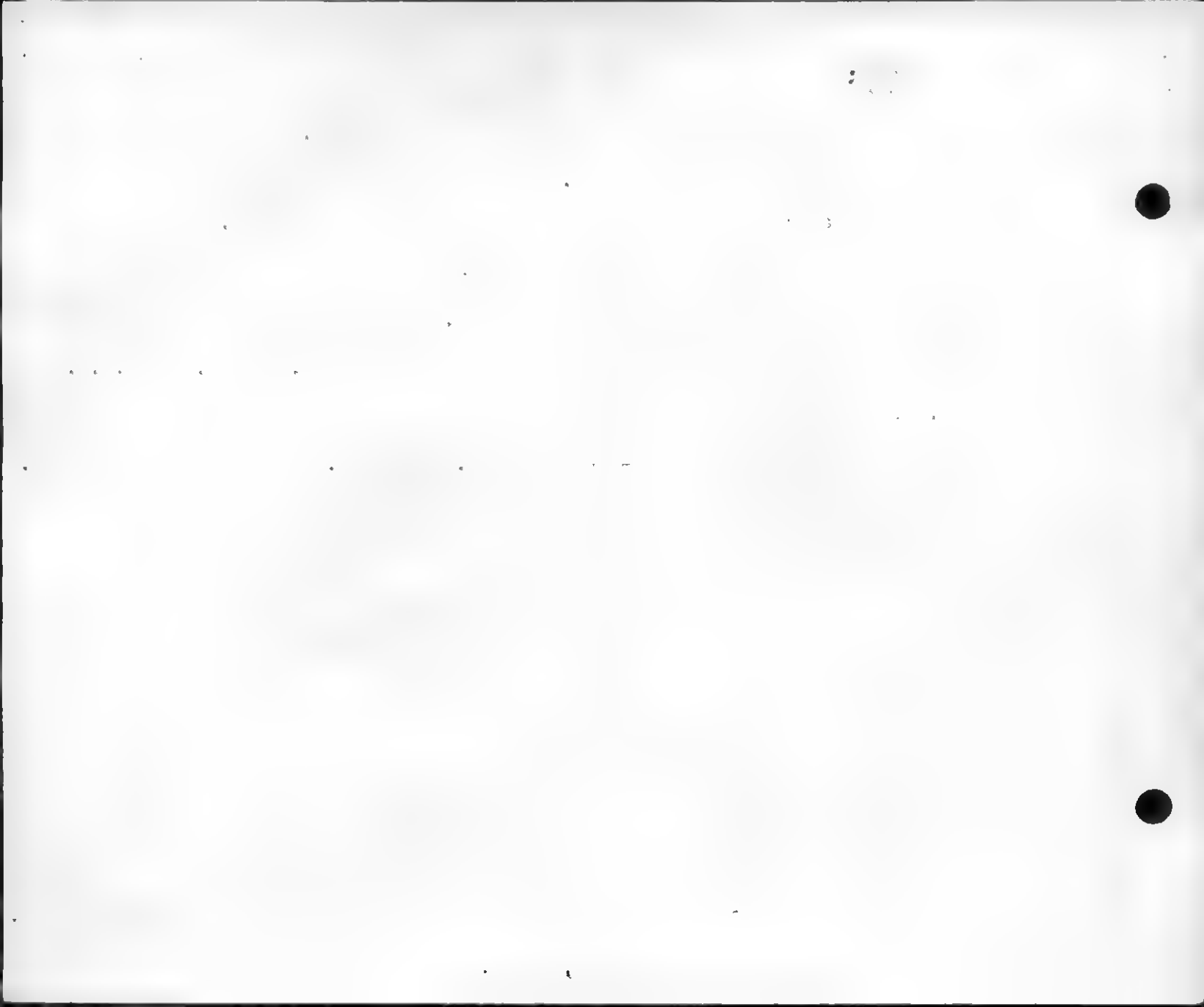
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07368

CERTIFICATE OF DEATH

07345

| | | | | | | | |
|---|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Penna. b. COUNTY Franklin ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown | | | | c. LENGTH OF STAY IN 1b 14 mo. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor | | | | d. STREET ADDRESS 135 Snider Ave. | | | |
| 3. NAME OF DECEASED (Type or print) First Harris Middle Newton Last Summer | | | | 4. DATE OF DEATH Month May Day 9 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 8, 1887 | 9. AGE (In years last birthday) 79 yrs | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Major | | | 10b. KIND OF BUSINESS OR INDUSTRY US Army | | 11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME B. R. Summer | | | | 14. MOTHER'S MAIDEN NAME May Duey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | | 16. SOCIAL SECURITY NO. 252-58-0875A | 17. INFORMANT Mrs. Rosalie S. Dayhoff Address Waynesboro, Pa. | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 22 , 19 66 to May 9 , 19 67 , that (I) (we) last saw the deceased alive on May 9 , 19 67 , and that death occurred at 6:20 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lloyd A. Hoffman M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/12/67 | |
| 22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | | | 22d. ADDRESS 214 N. Pot-st. Hagerstown, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5/12/1967 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill | | 23d. LOCATION (City & town) (County) (State) Waynesboro, Franklin, Penna. | |
| 24. FUNERAL DIRECTOR Walter J. Love Address Waynesboro, Penna. | | | | 25a. REC'D BY REGISTRAR MAY 17 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 14 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07363

CERTIFICATE OF DEATH

07346

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> | | | | c. LENGTH OF STAY IN 1b <u>60yrs.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | | | d. STREET ADDRESS <u>7 Braxton Av.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Cleo</u> Last <u>Summers</u> | | | | 4 DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5 SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 13 1896</u> | |
| 9 AGE (in years lost birthday) <u>71</u> yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg, Md.</u> | |
| 13. FATHER'S NAME <u>George H. King</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary V. Callaman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO <u>none</u> | | 17. INFORMANT <u>Mrs. Malcoma Brown</u> Address <u>243 N. Jonathan St.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> DUE TO <u>General Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio-Sclerosis</u> DUE TO (c) <u>General Arterio-Sclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 20/67</u> to <u>May 28/67</u> , that (I) (we) last saw the deceased alive on <u>May 28/67</u> and that death occurred at <u>9:00</u> M, from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>J. H. Beachley</u> | | | | 22b. PHYSICIAN'S NAME (Type) <u>J. H. Beachley</u> | | 22c. DATE SIGNED <u>May 30/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>June 1 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | |
| 24. FUNERAL DIRECTOR <u>John R. Watson Jr.</u> | | | | 25a. REC'D BY REGISTRAR <u>John R. Watson Jr.</u> | | 25b. REGISTRAR'S SIGNATURE <u>John R. Watson Jr.</u> | |





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

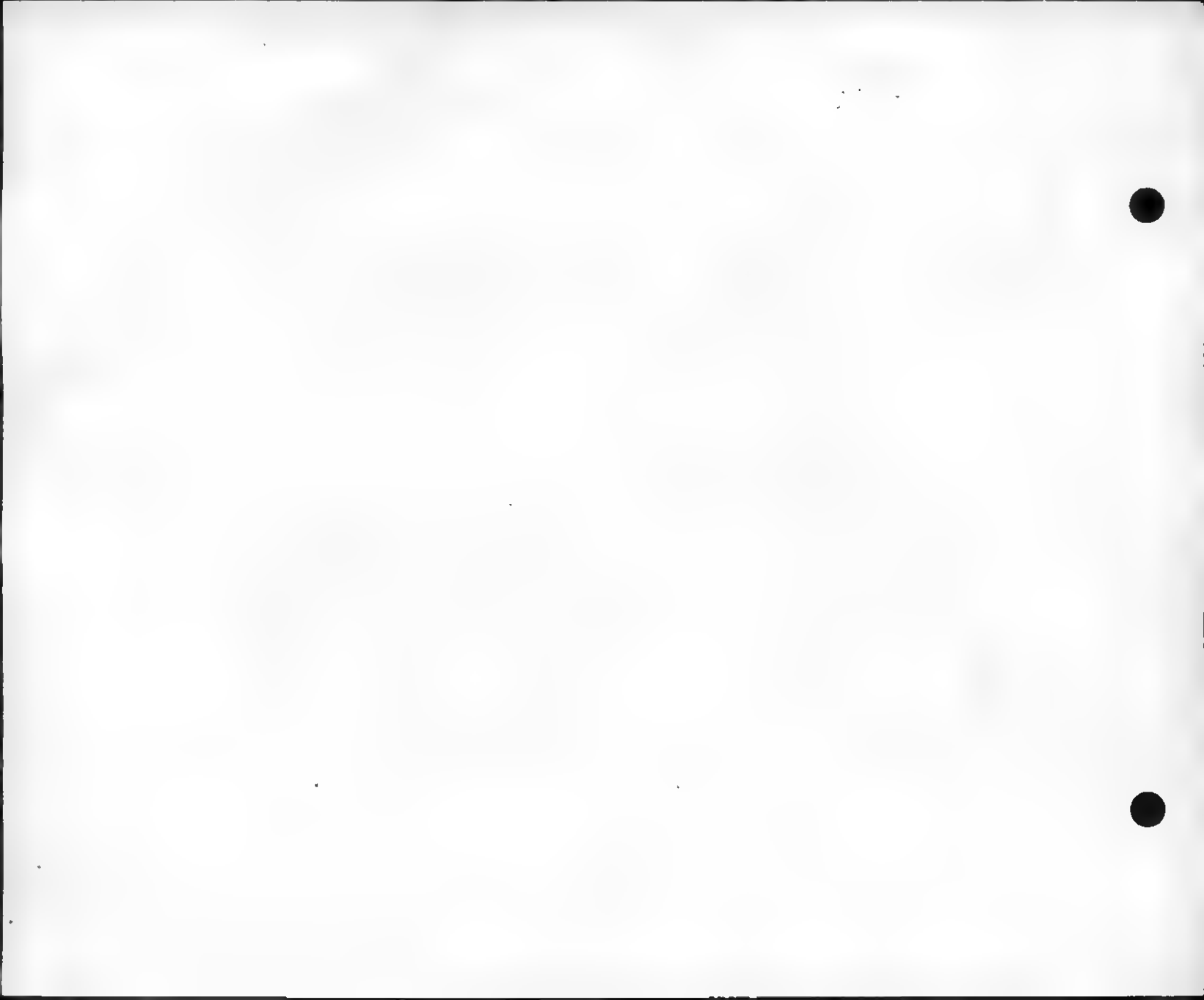
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| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN 1b 24 YEARS | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 446 WEST FRANKLIN STREET, | | | | d. STREET ADDRESS 446 WEST FRANKLIN STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last HENRIETTA EUGENIA TAYLOR | | | | 4 DATE OF DEATH Month Day Year MAY 27, 1967 | | | |
| 5 SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 19, 1867 | | 9 AGE (n years last birthday) yrs 99 | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11 BIRTHPLACE (County & State, or foreign country) CARROLL CO. MARYLAND. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME ANDREW F. FOWLER | | | | 14. MOTHER'S MAIDEN NAME CATHERINE E. LOOBY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***** | | | 16. SOCIAL SECURITY NO. 216-54-8419 | | 17. INFORMANT MRS. MARGUERITE E. HANN, HAGERSTOWN, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (b) Arteriosclerotic Cardio Vascular Disease (c) Senility | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) physician attended the deceased from May 1, 19 67 , to May 27, 19 67 , that (I) last saw the deceased alive on May 26, 19 67 , and that death occurred at 5 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE  | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED MAY 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) E. W. DITTO, JR. M.D. | | | | 22d. ADDRESS 215 W. WASHINGTON ST. HAGERSTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 5/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY WESTMINISTER CEMETERY | | 23d. LOCATION (City or Town) (County) (State) WESTMINISTER, CARROLL CO. MD. | |
| 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. | | | | 25a. REC'D BY REGISTRAR JUN 1 1967 | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

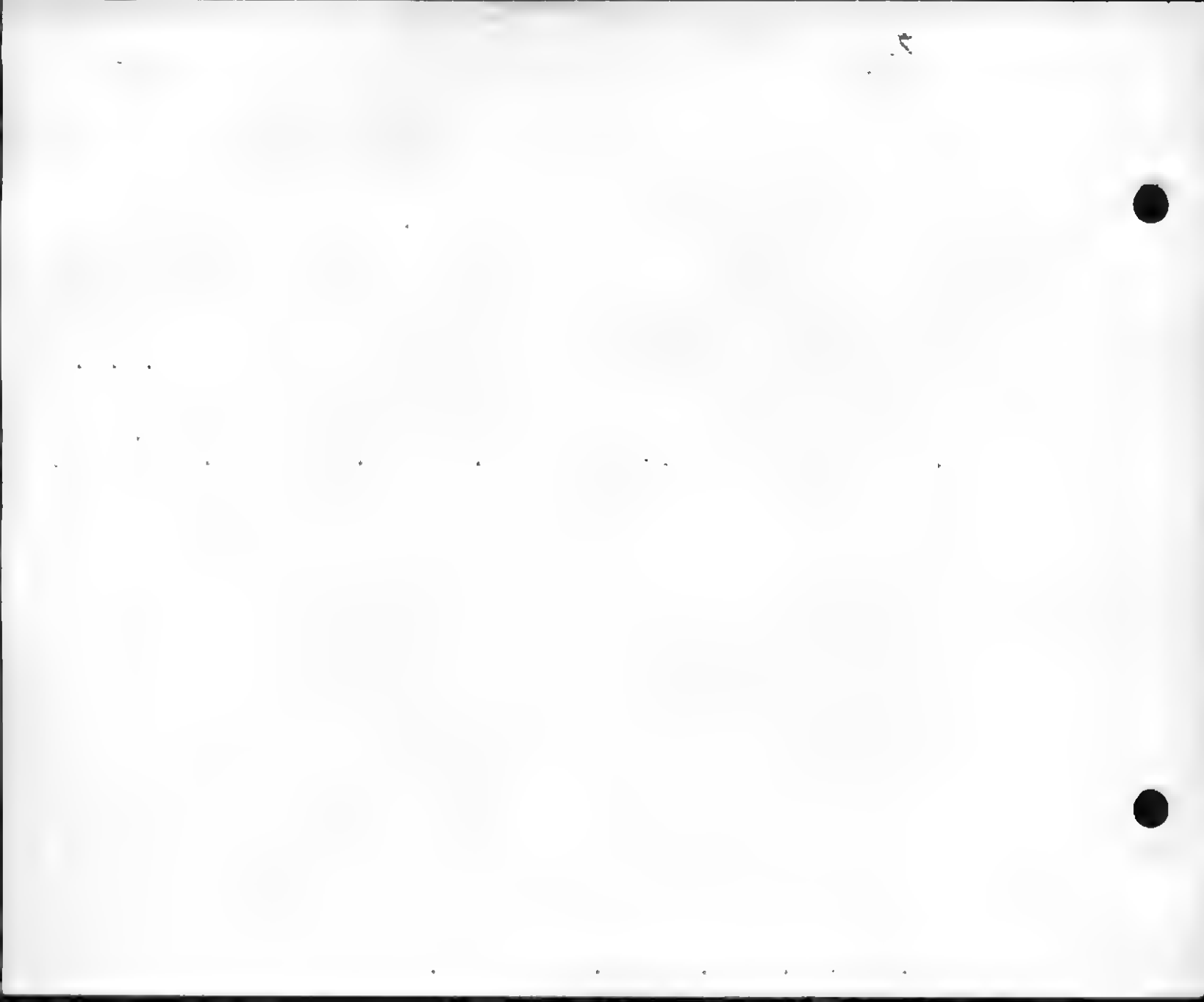
07371

07348

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a COUNTY Washington MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Washington | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c LENGTH OF STAY IN 1b 1 Day | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | d STREET ADDRESS Rfd. 1 | |
| e RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Jason Lester Thomas | | 4 DATE OF DEATH Month Day Year May 25, 1967 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH April 3, 1890 |
| 9 AGE (In years last birthday) 77 yrs. | | 10 IF UNDER 1 YEAR Months Days Hours Min 1 22 | 11 IF UNDER 24 HRS Hours Min 1 22 |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b KIND OF BUSINESS OR INDUSTRY Farming | 11 BIRTHPLACE (County & State, or foreign country) Rural Boonsboro, Md. |
| 12 CITIZEN OF WHAT COUNTRY? U. S. A. | | 13 FATHER'S NAME John Luther Thomas | |
| 14 MOTHER'S MAIDEN NAME Ellen Long | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | |
| 16 SOCIAL SECURITY NO. 215-36-7096 | | 17 INFORMANT Mrs. Nannie B. Thomas, Rfd. 1 Boonsboro, | |
| 18 ADDRESS Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension cardiac insada Curia DUE TO (b) Cerebral Haemorrhage DUE TO (c) 1 day | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 25, 1967 to May 25, 1967 , that (I) (we) last saw the deceased alive on May 25, 1967 , and that death occurred at 11 P. M. from causes and on the date stated above. | | | |
| 22a SIGNATURE G. W. LeVan | | 22b DATE SIGNED May 26, 1967 | |
| 22c PHYSICIAN'S NAME (Type) G. W. LeVan | | 22d ADDRESS Boonsboro, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 5-29-67 | 23c NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | 23d LOCATION (City or Town) (County) (State) Boonsboro, Md. |
| 24 FUNERAL DIRECTOR John H. Best, Jr. 112 N. Main St. Boonsboro, Md. | | 25a RECORD BY REGISTRAR MAY 31 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

Division of STATISTICAL RECORDS AND RECORDS, 301 W. PRISTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07349

1 PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland
c. LENGTH OF STAY IN 1b 6 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 115 Clarkson Ave.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY Washington
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Md
d. STREET ADDRESS 924 Watson Street

3 NAME OF DECEASED (Type or print)
First Middle Last
Simon (NMN) Walker
4 DATE OF DEATH May 17 19 67

5 SEX Male
6 COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☐
8 DATE OF BIRTH Jan 1 1893
9 AGE (In years last birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Cedar Hill, Va.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Jack Walker
14. MOTHER'S MAIDEN NAME Matilda Myers

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
16 SOCIAL SECURITY NO 217-07-5930
17 INFORMANT Mrs. Maude Myers 115 Clarkson Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 332X genual arteriosclerosis
(b) arteriosclerotic heart disease and
(c) cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH 25 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suspected adenocarcinoma prostate & metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year 19
Hour e.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Edward W. Ditto, III, M.D.
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.

22a. BURIAL, CREMATION, 22b. DATE THEREOF May 23 1967
22c. NAME OF CEMETERY OR CREMATORY National Cemetery
22d. LOCATION (City, town, or country) Baltimore, Maryland

23. FUNERAL DIRECTOR John R. Watson of Hagerstown Md.
24a REC'D BY REGISTRAR MAY 23 1967
24b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed within 72 hours after death. If any delay is necessary, it should be executed within 72 hours after death. If any delay is necessary, it should be executed within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07350

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-----------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 421 D, Sumans Ave | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, N. J. d. STREET ADDRESS 711 South 11th. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Earl (NMN) Ware | | 4. DATE OF DEATH Month Day Year May 11 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 18 1916 9. AGE (In years last birthday) 50 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Elkton, Va. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gilbert Ware | |
| 14. MOTHER'S MAIDEN NAME Carrie Taylor | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes World War 2 | |
| 16. SOCIAL SECURITY NO. 230-09-3627 | | 17. INFORMANT Jennie B. Ware Newark N. J. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) generalized arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward W. Ditto, III, M.D. EXAMINER'S NAME (Type) 22. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-16-1967 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown Md. 24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md. 25a. REC'D BY REGISTRAR MAY 16 1967 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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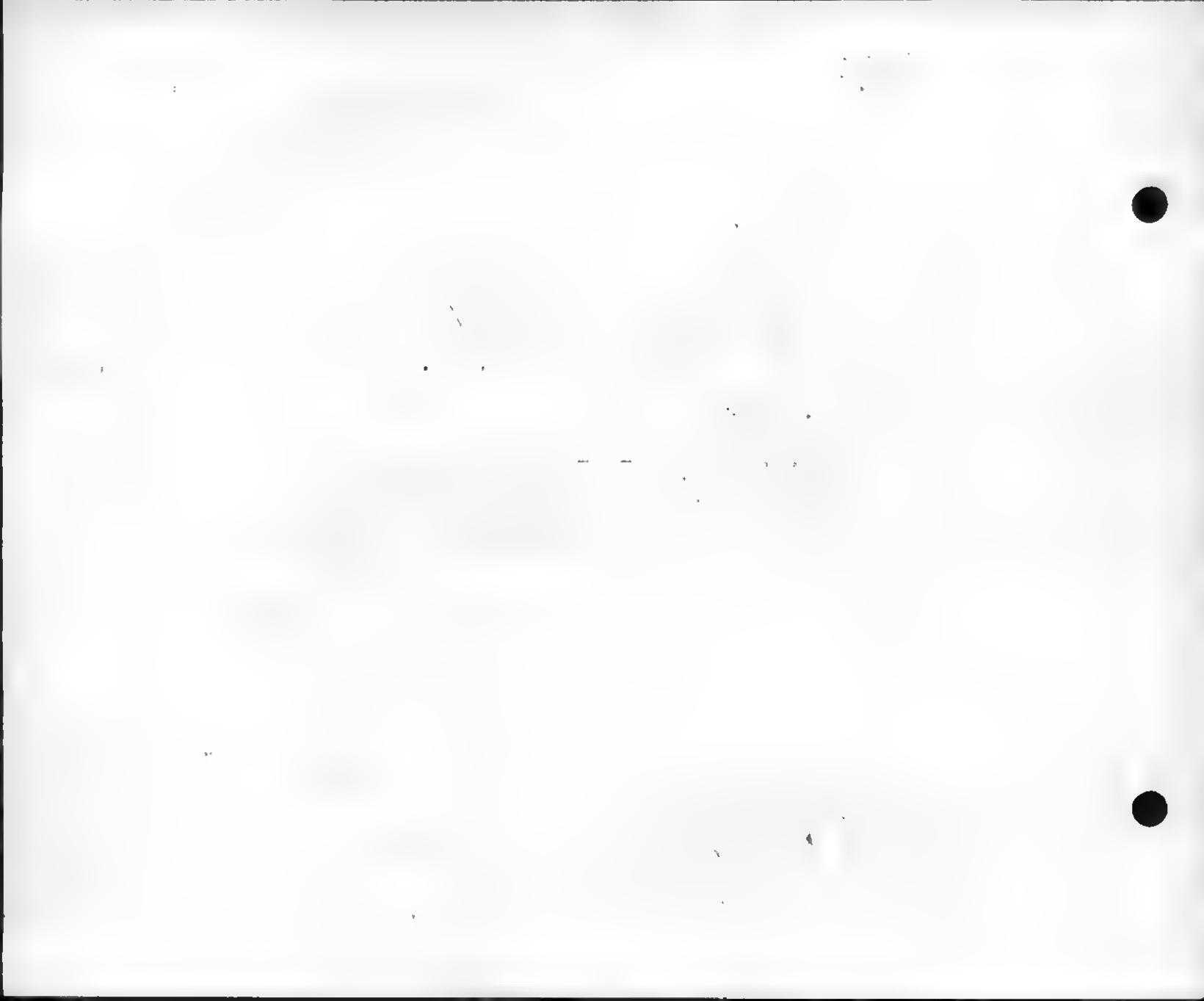
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07374

07351

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|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b 50 YRS. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 36 N. WALNUT ST. | | | | d. STREET ADDRESS 36 N. WALNUT ST. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First GUY Middle BOYD Last WETZEL | | | | 4. DATE OF DEATH Month MAY Day 10 Year 19 67 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/21/1913 | |
| 9. AGE (In years lost birthday) 53 yrs | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER | | | | 10b. KIND OF BUSINESS OR INDUSTRY SHEET METAL MFG. CO. VIRGINIA | | | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME HARVEY W. WETZEL | | | | 14. MOTHER'S MAIDEN NAME AUDREY ACORD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES W.W.#2 | | 16. SOCIAL SECURITY NO. 217-09-9666 | | 17. INFORMANT MR. CLYDE H. WETZEL | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Arteriosclerosis DUE TO (b) Anterior Myocardial Infarction DUE TO (c) Heart Disease | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Polycystic Degeneration | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-23 , 19 67 , to April 27, 1967 , that (I) (we) last saw the deceased alive on April 27, 1967 , and that death occurred at 6:00 p.m. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE E. R. Anderson | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 5-2-1967 | |
| 22c. PHYSICIAN'S NAME (Type) E. R. Anderson | | | | 22d. ADDRESS 300 D. Robinson, Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE THEREOF 5/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM. | | 23d. LOCATION (City or town) (County) (State) WILLIAMSPORT WASH. MD. | |
| 24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR DATE MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07375

CERTIFICATE OF DEATH

07352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> | | | c. LENGTH OF STAY IN TB <u>65yrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | | | d. STREET ADDRESS <u>410 Park Place</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Henry Wilkerson</u> First Middle Last | | | | 4. DATE OF DEATH <u>May 30</u> 19 <u>67</u> Month Day Year | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 8 1894</u> | | 9. AGE (In years last birthday) <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Burkittsville, Md.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Robert Wilkerson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Lucy Henderson</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>215-14-1370</u> | | 17. INFORMANT <u>Mrs. Josephine Wilkerson</u> | | Address <u>410 Park Pl.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Lymphogetous Leucemia</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>66</u> to <u>May 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> 19 <u>67</u> , and that death occurred at <u>12 P</u> M, from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert P. Conrad</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>6-1-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u> | | | 22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>June 3 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>John R. Watson Jr. Hagerstown Md.</u> | | | 25a. REC'D BY REGISTRAR DATE <u>JUN 2 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07376

CERTIFICATE OF DEATH

07353

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| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 N. Mont Ualla Ave.</u> | | d. STREET ADDRESS <u>329 Elizabeth Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Gussie</u> Middle <u>Virginia</u> Last <u>Willis</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 67</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 1, 1904</u> |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Mfg.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Leetown, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Bush Rod Willis</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Belle Martin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-09-7913</u> | |
| 17. INFORMANT <u>Mrs. Mae E. Rockwell</u> | | Address <u>Ragerstown, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardiac Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 Day</u> <u>2-3 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease; Cardiac failure</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>13 March, 1965</u> to <u>17 May, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 1965</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard T. Binford</u> M.D. | | 22b. DATE SIGNED <u>19 May 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Richard T. Binford, M. D.</u> | | 22d. ADDRESS <u>1135 Potomac Avenue Hagerstown, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>May 20, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25a. RECEIVED BY REGISTRAR <u>MAY 19 1967</u> DATE | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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